

October DY6 Reporting – Companion Document

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OCTOBER REPORTING CHECKLIST

Please review this checklist to ensure you have completed all items for October reporting. This checklist is for informational purposes only and does not need to be submitted with October reporting materials.

- ☐ October DY6 Reporting information entered and saved in the online system – "Reporting Status" tab indicates "Ready to Submit" or "Report Submitted" for all sections. (As long as the completed reports and supporting attachments have been **saved** by the reporting deadline, they will be considered officially submitted.)
- ☐ Semi-annual reporting requirements met:
 - ☐ "Provider Summary Report" completed in the online reporting system.
 - For each project:
 - ☐ "M-3: Project Summary and Core Components" tab – all questions answered online for each Category 1 or Category 2 DSRIP project.
 - ☐ "Progress Update" field – completed online for each Category 1 or Category 2 metric and each Category 3 milestone.
 - ☐ QPI Reporting Template – for **ALL** DY6 QPI metrics, even if the provider is not reporting for achievement.
- ☐ (If applicable) DY5 Carryforward Reporting information entered into the online system. Carryforward milestones appear with an asterisk on the current year's Project Reporting page.
- ☐ Coversheet(s) completed and uploaded. (One Coversheet per Category 1 or 2 project, unless an additional Coversheet is needed due to the number of metrics reporting achievement.)
- ☐ Supporting documentation uploaded to the DSRIP Online Reporting System under "Supporting Attachments" for metrics reporting achievement. (Minimum of 1 supporting document uploaded for each Category 1 or 2 metric, but the same document may be used to demonstrate achievement for multiple metrics if appropriate).
 - ☐ Document name should include RHP, Project ID, and Metric ID
- ☐ **October DY6 QPI Reporting Template** completed and uploaded for **ALL** DY6 QPI metrics and to report achievement of DY5 Carryforward QPI metrics.
 - ☐ Save as: RHPXX_ProjectID_QPI_OctDY6 (RHP01_123456789.1.1_QPI_OctDY6)
- ☐ **October DY6 Sustainability Template** completed and uploaded for DY6 M-4.1 metrics reporting achievement (1 template per provider per region).
 - ☐ Save as: RHPXX_TPIXXXXXX_M4_OctDY6 (RHP01_123456789_M4_OctDY6)
- ☐ **Category 3 October DY6 Reporting Template & Certification** completed and uploaded to report achievement of DY6 and DY5 Carryforward milestones (1 template per provider).
 - ☐ Save as: RHPXX_TPIXXXXXX_Cat3_OctDY6 (RHP01_123456789_Cat3_OctDY6)
- ☐ (If applicable) *Category 3 Stretch Activity 3 (SA3) Program Evaluation Coversheet* completed and uploaded along with the full program evaluation for each PM-11 Stretch Activity 3 (Program Evaluation) milestone.
 - ☐ Save SA3 Coversheet as: RHPXX_Cat3ProjectIDXXXXXXXX.X.X_SA3_OctDY6 (RHP01_123456789.3.1_SA3_OctDY6)
- ☐ (If applicable) *Category 3 Stretch Activity Report* completed and uploaded directly to the PM-11 Stretch Activity milestone. *HHSC does not require a coversheet for Stretch Activities other than SA3.*
 - ☐ Save as: RHPXX_Cat3ProjectIDXXXXXXXX.X.X_SA#_OctDY6 (RHP01_123456789.3.1_SA9_OctDY6)
- ☐ (If applicable) **Category 4 Reporting Template** completed and uploaded. (One template per hospital provider participating in Category 4).
 - ☐ Save as: RHPXX_TPIXXXXXX_Cat4_OctDY6 (RHP01_123456789_Cat4_AprDY6)
- ☐ All items listed above submitted through the DSRIP Online Reporting System no later than **11:59 p.m. on October 31, 2017.**
- ☐ (If applicable) IGT changes in entities or proportion of IGT among entities submitted to HHSC (TXHealthcareTransformation@hhsc.state.tx.us) using the *IGT Entity Change Form* by **December 1, 2017, 5:00 p.m.** (One IGT Entity Change Form per provider).

KEY POINTS FOR OCTOBER DY6 REPORTING

Each DSRIP provider should review this entire Companion document to understand the guidelines for how to report DSRIP achievement for the October DY6 reporting period. The Companion Document includes important information about changes to required documentation compared to what was required for DY5 reporting.

Below are several critical points HHSC wants to highlight.

- **Reporting Exceptions for Providers Impacted by Hurricane Harvey¹:** HHSC and CMS have agreed upon several changes to DSRIP DY6 reporting in light of the issues caused by Hurricane Harvey. The reporting exceptions outlined below will apply only to providers in FEMA designated disaster counties (see footnote) which are mainly located in RHPs: 2, 3, 4, 7, and 17.

- The requirement for UC-only hospitals impacted by the hurricane to attend a regional learning collaborative in DY6 has been waived.
- Impacted providers may use an alternate measurement period for Category 3 outcome measures for Performance Years (PY) 3 and 4. The exceptions might include an 11 month measurement period instead of 12, or a gap in the data to account for hurricane recovery time. Providers will indicate their need for a change to the measurement period in the Category 3 Reporting Template.
- Impacted providers that are not able to submit complete information during the October DY6 reporting period may request that DY6 metrics with low risk of recoupment be provisionally approved through the Hurricane Response Template. Metrics eligible for provisional approval include:
 - Category 1-2 M-3 (Project Summary and Core Components) milestones
 - Category 1-2 M-4 (Sustainability Planning) milestones
 - Category 4 reporting domains

Provisionally approved metrics are eligible for payment with other approved metrics in January 2018. Impacted providers who receive provisional approvals for these metrics will be required to submit complete information during the extended NMI reporting period. Provisional payments will be recouped if complete information is ultimately not submitted and/or the provider does not respond to requests for additional information. Providers requesting provisional approvals and payment will need to confirm their requests using a special form. HHSC will reach out to impacted providers with specific instructions.

- Impacted providers who request carryforward for DY6 QPI milestones M-1 or M-2 will have the opportunity to report carryforward achievement early, during the regular NMI reporting period (by January 16, 2018). Providers who use this opportunity will be eligible for an off-cycle payment to occur in March 2018. Quick turnaround will be required if HHSC requests additional information following the January 16, 2018, submission of the QPI template with DY6 carryforward data. This exception is intended to accommodate impacted providers

¹ Providers impacted by Hurricane Harvey are providers located in counties designated by FEMA for Individual Assistance and Public Assistance (Categories A and B) or Individual Assistance and Public Assistance (Categories A-G). Source: <https://www.fema.gov/disaster/4332>

who were on track to achieve DY6 QPI goals but experienced reduced volume following the hurricane.

- The “Needs More Information” (NMI) reporting period that follows the initial October DY6 reporting review period will be extended for impacted providers/projects from January 16, 2018, to February 28, 2018, to allow additional time to report.
 - Example 1: An impacted provider is in a situation where they are unable to complete any of their October DY6 reporting in the reporting system. In this case, HHSC will mark their milestones, metrics, and SAR as “Needs More Information” and/or “Incomplete” and the provider will need to complete these required semi-annual reporting items, including carryforward requests for eligible metrics/milestones, during the extended NMI reporting period by February 28, 2018. HHSC will review reporting submissions before the April DY7 reporting period, and any milestones/metrics approved during the extended period will be paid in July 2018.
 - Example 2: An impacted provider completes their Provider Summary, requests provisional approval of their M-3 and M-4 milestones, and requests to carryforward their DY6 QPI milestones (M-1 and/or M-2) into DY7.
 - In this case, HHSC will approve payment for the M-3 and M-4 milestones, but will mark them as “Needs More Information.” The provider must submit completed templates or additional information for milestone M-3 and M-4 by the extended NMI deadline of February 28, 2018.
 - For the DY6 QPI milestones that were carried forward into DY7, HHSC may also mark them as “Needs More Information” with a message to impacted providers to see if the provider would like the opportunity to report their DY6 carryforward QPI metrics early. In order to be eligible for the early payment (estimated to be in March 2018), the provider must submit their DY6 carryforward QPI template by the normal NMI reporting deadline of January 16, 2018.
- **DY6 DSRIP Online Reporting System Changes:**
 - The button that provides access to the Provider Summary reporting page has been moved to the Provider Summaries tab on the Provider Details page.
 - During the October DY6 reporting period, the Project Summary April DY6 tab will be read-only. Instead, the Project Summary and Core Components milestone (M-3) will be open and completion of this milestone will count towards the Project Summary SAR requirement since it shares many of the same questions.
 - Providers may report achievement or request carryforward of DY6 QPI (M-1) and DY6 MLIU QPI (M-2) during the October DY6 reporting period. October DY6 is the only opportunity to report achievement of the Project Summary and Core Components (M-3) and Sustainability (M-4) milestones as they are not eligible to be carried forward.
 - The M-4 Progress Update field will house the location of the October DY6 Sustainability template and instructions for submission of the template. The template will count towards the completion of the Progress Update SAR requirement.
 - For projects that were combined into other projects for DY6 and beyond, the provider must report achievement of DY5 carryforward metrics on the original project's reporting page.

- Projects that have been discontinued in DY6 and beyond will still have the opportunity to report on their DY5 carryforward metrics. Once these projects have completed reporting on their DY5 carryforward metrics, they will be deactivated.
- **Reporting Achievement:** Metrics/milestones should only be reported in October if a provider is confident that the metric/milestone was fully achieved by **September 30, 2017**, and can be clearly demonstrated. For any metric/milestone that HHSC does not find sufficient evidence of achievement in the documentation, the provider will only have one opportunity in December/January to submit additional information. If the provider cannot demonstrate during the December/January "needs more information" (NMI) period that the metric/milestone was completed by **September 30, 2017**, the provider will no longer be eligible for payment for that metric/milestone.
- **Semi-annual Reporting (SAR):** All providers are required to provide semi-annual reporting information regardless of whether the provider is reporting achievement of metrics/milestones for payment in October. Future DSRIP payments may be withheld until the complete report is submitted. (p. 8)
 - The "Provider Summary Report" must be completed by all providers as part of the provider-level Semi-Annual Reporting requirement.
 - For each project, all providers should complete:
 - the "M-3: Project Summary and Core Components" tab – all questions must be answered for each Category 1 or Category 2 DSRIP project.
 - the "Progress Update" field – must be completed for each Category 1 or Category 2 metric and each Category 3 milestone.
 - QPI Reporting Template – for **ALL** DY6 QPI metrics, even if the provider is not reporting for achievement.
- **Reporting Deadline:** Providers should report using the DSRIP Online Reporting System: <https://dsrip.hhsc.texas.gov/dsrip/login> by **11:59 p.m.** on **October 31, 2017**.
- **Reporting Materials:** Companion documents and reporting templates can be found on the **DSRIP Bulletin Board** in the DSRIP Online Reporting System. Please note that separate templates are required for QPI reporting, Category 3 reporting, and Category 4 reporting.
 - User Guide for the DSRIP Online Reporting System
 - DY6-DY8 Reporting Coversheet
 - Learning Collaborative Participation Template – This template is not required, but includes suggested elements for Lessons Learned documentation for DY5 carryforward Learning Collaborative metrics.
 - Quantifiable Patient Impact (QPI) Reporting
 - October DY6 QPI Reporting Companion
 - October DY6 QPI Template - Please be sure to download the new QPI Reporting Template from the Waiver website as data has been updated and pre-seeded in the template.
 - Category 3 Reporting
 - Category 3 October DY6 Reporting Template
 - Category 3 Stretch Activity 3 (SA3) Coversheet Template
 - Category 4 Template

Please send reporting questions to the HHSC waiver mailbox at TXHealthcareTransformation@hhsc.state.tx.us. Please remember to include your RHP, Project ID, and Metric ID when submitting your questions.

OVERVIEW

This document includes information on reporting during the second reporting period of DY6 including timelines, DY5 carryforward instructions, use of *Coversheets* and other HHSC reporting templates, QPI guidance, guidance on supporting documentation, and an overview of payment and IGT processing.

For technical instructions on using the DSRIP Online Reporting System, please refer to the *DSRIP Online Reporting System User Guide* posted on the **DSRIP Bulletin Board** in the DSRIP Online Reporting System. Please note that the reporting system refers to April reporting as Round 1 and October reporting as Round 2.

Supporting documentation submitted in previous reporting periods outside of the DSRIP Online Reporting System (August DY2, October DY2, April DY3, and October DY3 provisional NMI period) is not available on the online reporting system.

There are two opportunities to report achievement of milestones and metrics in DY6: April and October 2017.

- Milestones and metrics achieved by March 31, 2017, may be reported in April.
- Milestones and metrics achieved by September 30, 2017, may be reported in October.
- October 2017 is the final opportunity to report achievement of DY5 carryforward milestones and metrics.
- Changes submitted through the Change Requests (Plan Modification and Technical Change Requests) process in August 2014 for DY4 and DY5 are completed and no further changes will be considered unless requested by HHSC. If there are variations in baselines or previously reported achievement, please address it in reporting as outlined in **Appendix A** of this companion document under "General Guidance for Non-QPI Metrics" on p. 37

OCTOBER REPORTING TIMELINE

- **October 1, 2017** – The DSRIP Online Reporting System will open for providers to begin October DY6 reporting. The templates for *Coversheets*, QPI reporting, DY6 Sustainability milestone (M-4), Category 3, and Category 4 will be posted to the DSRIP Bulletin Board as soon as they are available.
- **October 4, 2017** – HHSC will be holding an October DY6 Reporting Webinar from **10:00 am – 12:00 pm** which will cover General Reporting, Quantifiable Patient Impact (QPI), and Category 3 guidance.
- **October 20, 2017** - Final date to submit questions regarding Category 3 April reporting and inform HHSC of any issues with DY6 data in the Category 3 reporting template or online reporting system.
- **October 25, 2017** – Final date to submit Category 1, 2, and 4 questions regarding October reporting and inform HHSC of any issues with DY6 data in the reporting system.
- **October 31, 2017, 11:59pm** – Due date for providers' submission of October DY6 DSRIP reporting using the DSRIP Online Reporting System and upload of applicable *Coversheets*, supporting

documentation, and QPI, Sustainability, Category 3 and Category 4 templates. Late submissions will not be accepted.

- **November 1, 2017** – HHSC will begin review of the October reports and supporting documentation.
- **November 17, 2017** – HHSC will post the estimated IGT due for October reporting based on milestones and metrics reported as achieved. Final IGT due will be based on HHSC review and approval.
- **November 20, 2017, 5:00pm** – Due date for IGT Entities to approve and comment on their affiliated providers' October reported progress on metrics using the "IGT Info" tab for each project. The tab is not an opportunity to identify technical errors entered in the reporting system. Examples of issues to include are reported progress that was not actually achieved, changes in project scope that were not reported by the provider, and risks to the project that were not reported by the provider. If there are no issues, comments do not need to be submitted and HHSC will assume the IGT Entity has approved the reported information. ***If there is a need to identify any technical errors in the reporting system please use the Waiver mailbox to communicate those errors by October 25, 2017, as stated above.***
- **December 1, 2017, 5:00pm** – Due date for submission of any IGT changes in entities or proportion of IGT among entities submitted to HHSC (TXHealthcareTransformation@hhsc.state.tx.us) using the [IGT Entity Change Form](#).
- **December 8, 2017** – HHSC and CMS will complete their review and approval of October DY6 reports or request additional information (referred to as NMI) regarding the data reported. Note that HHSC completes multiple levels of review prior to determining that a milestone/metric requires additional information.
 - If additional information is requested, the DSRIP payment related to the milestone/metric will not be included with January DSRIP payments.
- **January 3, 2018** – IGT settlement date for October reporting DSRIP payments.
- **January 16, 2018, 11:59pm** – Due date for providers to submit responses to HHSC requests for additional information (NMI requests) on October reported Category 1-4 milestone/metric achievement and Semi-Annual Reporting requirements. Please include "NMI" in the file name when uploading documentation in response to NMI requests. ***This is also the due date for hurricane-impacted providers who choose to report early for DY6 carryforward of QPI milestones in order to qualify for an off-cycle payment in March 2018. HHSC will follow up with eligible providers regarding IGT due dates for milestones that are approved.***
- **January 17, 2018** – October reporting **DY6 DSRIP payments** processed for transferring hospitals and top 14 IGT Entities.
- **January 31, 2018** – October reporting **DY5 DSRIP payments** processed for all providers and **DY6 DSRIP payments** processed for remaining providers that were not paid on January 17, 2018. Note that there are separate transactions for each payment for each DY.
- **February 23, 2018** - HHSC and CMS will approve or deny the additional information submitted in response to HHSC comments on October reported milestone/metric achievement. Approved reports will be included for payment in the next DSRIP payment period, estimated for July 2018. For hurricane-impacted providers reporting early for DY6 QPI carryforward, payments for approved DY6 QPI carryforward milestones will occur in March 2018.

- **February 28, 2018, 11:59pm** – (If Applicable) Due date for hurricane-impacted providers to submit responses to HHSC requests for additional information (NMI requests) on October reported Category 1-4 milestone/metric achievement and Semi-Annual Reporting requirements. Please include "NMI" in the file name when uploading documentation in response to NMI requests.
- **March 23, 2018** – (If Applicable) HHSC and CMS will approve or deny the additional information submitted during the extended additional reporting period in response to HHSC comments on October reported milestone/metric achievement. Approved reports will be included for payment in the next DSRIP payment period, estimated for July 2018.

REQUIRED SEMI-ANNUAL PROGRESS REPORTS

According to the Program Funding and Mechanics Protocol, paragraph 17 (on p. 351 of the waiver amendment approved October 24, 2014), semi-annual progress reports must be submitted to HHSC and CMS. DSRIP payments may be withheld until the complete report is submitted. To meet this requirement, **all providers are required to complete the items below during the April and October reporting periods in a given demonstration year for every project regardless of whether the milestone/metric is reported for payment.** All information will be entered into the online reporting system.

- “Provider Summary Report” - This is a brief overview of your project/s current progress, activities conducted, findings, and outcomes achieved. Providers with multiple projects may submit an executive summary overview of all of their projects in the Provider Summary. Responses should be succinct and provide brief relevant detail.
- For each project:
 - “M-3: Project Summary and Core Components” tab – all questions must be answered for each Category 1 or Category 2 DSRIP project. **Please note to meet DY6 SAR requirements, the provider must complete the Project Summary and Core Components milestone (M-3) tab during the October DY6 reporting period. The Project Summary April DY6 tab will be read-only during the October DY6 reporting period.*
 - For detailed guidance on how to complete the M-3 tab, please refer to the “M-3: Project Summary and Core Components Milestone” section on p. 11.
 - “Progress Update” field – **must be completed for each Category 1 or Category 2 metric and each open Category 3 milestone.** This should be a succinct summary (one to several sentences as needed), e.g.:
 - (If completed) - Two pediatricians were hired in February 2015 and they have begun to serve patients at the neighborhood clinic.
 - (If in progress) – One pediatrician was hired in December 2014. We continue to advertise for the second pediatrician and hope to have them hired by the end of 2015.
 - (If not completed yet) – We began to advertise to hire the two pediatricians in January 2015. We are interviewing now, but have not yet hired either pediatrician. The goal is to have both of them hired and serving patients by the first quarter of 2016.
 - *QPI Reporting Template.* In order to capture the annual impact of DSRIP, HHSC requires providers to complete the QPI Reporting Template for **ALL** DY6 QPI metrics, even if the provider is not reporting for achievement or previously reported achievement in April DY6. As the

template is at the project level and contains both DY6 QPI metrics, the provider only needs to submit one template per project.

DY5 CARRYFORWARD REPORTING

- Reporting Achievement of DY5 Carryforward Metrics for Category 1-2
 - The carried forward DY5 milestones and metrics are included in the online system under DY6 Round 2 along with the DY6 milestones and are identified with an asterisk. For Category 1 and 2 carried forward milestones and metrics, please follow the guidance included in **Appendix A** starting on p. 37.
 - DY5 carryforward metrics for projects that were combined under another project for DY6 and beyond should be reported on the Project Reporting page associated with their DY5 Project ID.
 - For example, RHP 2 - 123456789.1.1 was combined into RHP 3 - 123456789.1.3. Any DY5 metrics that requested carryforward for RHP 2 - 123456789.1.1 will appear on the DY6 project reporting page for RHP 2 - 123456789.1.1. Meanwhile, the DY6 project reporting page for RHP 3 - 123456789.1.3 will display the DY6 milestones for the combined projects and any DY5 carryforward metrics from project RHP 3 - 123456789.1.3.
 - Note that if you are reporting on a carried forward percentage improvement metric that is included in the previous DY and the current DY, then the carried forward metric must be demonstrated prior to the current metric. For example, a project includes metric I-10.1 in both DY3 and DY4. Its DY3 goal is a 10% decrease in no-show rates from DY2 baseline and its DY4 goal is a 15% decrease in no-show rates from DY2 baseline. The provider requested carryforward because the DY2 no-show baseline rate was not determined until DY3 - June 2014. To report achievement of the DY3 goal, a minimum of six months of data (July 1, 2014-December 30, 2014 in this example) must be used to demonstrate 10% decrease from the baseline. The DY3 carried forward metric could be reported in April or October 2015. Because this is an annual metric, the DY4 achievement of 15% decrease from the baseline should only be reported in October and use a 12-month period (Oct. 1, 2014-Sept. 30, 2015 in this example). Because this percentage improvement metric is not a QPI metric, the DY4 12-month period may overlap with the period used for reporting DY3 carryforward. Overlapping measurement periods are not allowed for QPI metrics.
- Reporting Achievement of DY5 Carryforward Milestones for Category 3
 - The carried forward DY5 milestones are included in the online system under DY6 Round 1 along with the DY6 milestones and are identified with an asterisk.
 - DY5 carryforward milestones for Category 3 projects that were combined under a different Category 1 or 2 project for DY6 and beyond should be reported on the Project Reporting page associated with their DY5 Category 1 or 2 Project ID.

REQUESTING CARRYFORWARD FOR DY6 MILESTONES AND METRICS

The option to carryforward DY6 milestones is available during October reporting. Please note that for Category 1 & 2, only the QPI DY6 milestones (M-1 and M-2) may be carried forward into DY7. Milestones

M-3 and M-4 are NOT eligible for carryforward and must be completed during the October DY6 reporting period.

If a milestone or metric will not be achieved by September 30, 2017, under "Achieved by Sept 30?" please select "Partially Completed" or "No-Not Started." To request carryforward, answer the "Carryforward Questions" for each Category 1 or 2 metric or Category 3 milestone on the Round 2 milestone tab:

- Enter a response for "If applicable, please explain why your achievement is less than expected."
- Select **"Yes"** for "Do you want to carry this metric into the next demonstration year?"
- Enter a response for "What is your plan to improve performance by the end of the following DY?"

For Category 1-2 QPI metrics, a completed QPI template must be submitted along with the carryforward request as it is part of the semi-annual reporting (SAR) requirements.

Category 3 DY6 achievement milestones (e.g., AM-3.1) that are partially achieved by September 30, 2016, may also be carried forward for remaining achievement. See "Category 3: Partial Payment and Carryforward" on p. 21.

CATEGORY 1 AND 2

There are four standard milestones for each active project in DY6: M-1 Total QPI, M-2 MLIU QPI, M-3 Project Summary and Core Components, and M-4 Sustainability Planning.

M-1 and M-2: QPI Milestones

If a provider is reporting achievement of a DY5 QPI carryforward metric in October for payment, it must demonstrate in the *QPI Template* that the QPI goal was achieved between October 1, 2015 and September 30, 2017. If a provider is reporting achievement of a DY6 QPI milestone in October for payment, it must demonstrate in the *QPI Template* that the QPI goal was achieved between October 1, 2016 and September 30, 2017. There cannot be an overlap of the demonstration year dates used to count achievement for different years. In other words, once the DY5 QPI carryforward metric is met or forfeited, counting toward the DY6 Total QPI milestone and MLIU QPI milestone achievement can begin.

In DY6, there are two QPI milestones: M-1 Total QPI and M-2 MLIU QPI. Providers may report on these two milestones during the October DY6 reporting period if the provider has achieved or forfeited the project's DY5 QPI metric. DY6 MLIU QPI milestones that are designated as pay-for-reporting (P4R) may report in October as long as the provider has served at least one MLIU patient above the MLIU pre-DSRIP baseline and has achieved or forfeited their DY5 QPI metric.

Providers are required to submit an October DY6 QPI reporting template, regardless of metric achievement, as it is required as part of SAR requirements. Providers should only submit one *QPI Reporting Template* per project per reporting period. The same template is used for DY5 carryforward QPI metrics, DY6 Total QPI milestone, and the DY6 MLIU QPI milestone. The template has been updated for October DY6 reporting; a provider that is reporting for DY5 carryforward or DY6 metric achievement must download the October DY6 template from the DSRIP Bulletin Board so that they can use a

template with properly seeded project data. If a DY5 project has been combined into a new project ID for DY6, the provider will find the reporting fields for any DY5 carryforward metrics in the template under the new DY6 QPI project ID.

Please read the *QPI Reporting Companion Document* carefully before entering any information in the QPI template and refer to Instructions included in the first tab of the *QPI Template* workbook for general guidance.

M-3: Project Summary and Core Components Milestone

Providers may only report on milestone M-3 during the October DY6 reporting period and it is NOT eligible to be carried forward into DY7. Please note that this milestone does not have an “Achieved by March 31?” dropdown field for the provider to indicate that they are reporting achievement. Instead, a provider must complete all data entry fields in order for the milestone to not interfere with the project’s reporting status.

Milestone M-3 has three sections: Project Overview, Core Components, and Meetings. The **Project Overview** section is comprised of three former Project Summary questions related to the project’s accomplishments, challenges, and lessons learned for DY6. Under “Project Overview: Accomplishments,” the provider should describe positive change, forward progression with overall project success (e.g., We have hired a new clinician which will allow us to extend our clinic hours soon.) If there were any variations (difficulties and how they were addressed/plans to address) from the project narrative and metrics that have already been reported as achieved, please provide this information under “Project Overview: Challenges” (e.g., We hired two nurses to meet a DY3 metric, but one of them moved out of the area and we’ve been unable to refill that position. This may impact our ability to achieve our QPI metrics.). Under “Project Overview: Lessons Learned” describe what worked well, what could be improved, and how it can aid progress (e.g., Incorporating our new patient navigator into the ED team has helped us lower the rate of episodic care in the ED, but we realize that the workload may require additional staff. Patient navigation services could be improved by increasing navigation staff and cultural competency).

The **Progress on Core Components** Section will be pre-populated with the required core components based on the project’s project option, as listed in the program protocols. Under each core component, the provider should describe their progress through the end of demonstration year. Please note that some project options may not have required core components. If the project is doing any optional core components or continuous quality improvement (CQI) activities that the provider would like to document in their reporting submission, then please include their progress in the responses to the “Accomplishments,” “Challenges,” or “Lessons Learned” questions (where applicable). There may also be core components listed that the provider may not be implementing for their project. In this situation, the provider should note that they are not implementing the core component and explain why.

In the **Meetings** section, the provider should select “Yes” and enter the number of learning collaborative, stakeholder forum, or other stakeholder meetings that the provider participated in during DY6 in order to open up additional reporting questions about the meetings attended by the provider

during DY6. The provider may report up to 3 meetings. For each meeting, the provider should enter (1) a brief description of the meeting (title, host, etc.), (2) the date of the meeting, (3) names and titles of provider staff who attended and participated in the meeting, (4) lessons learned from the meeting, and (5) how the provider plans on applying what they learned from the meeting to their DSRIP project. Unlike the learning collaborative metrics from DY2-5, documentation is not required for this metric, as the questions are in the reporting system instead of a separate template for DY6, the provider should maintain attendance documentation for their records in case of audit. It is also important to note that the provider **must have attended/participated in one learning collaborative, stakeholder forum, or other stakeholder meeting during DY6** in order to earn funds for milestone M-3.

In addition to these three sections, there are also some providers who have required **Next Steps**. This information will be pre-populated in the online reporting system at the bottom of the M-3 milestone tab. A data entry field will be available for the providers to enter their progress and they will also have access to an upload button to upload relevant supporting documentation.

M-4: Sustainability Planning Milestone

The provider may only report achievement of their M-4 milestone during the October DY6 reporting period. This milestone is **NOT** eligible to carryforward into DY7.

To report achievement of the sustainability milestone, the provider must complete the DY6 Sustainability Template, which can be found on the **DSRIP Bulletin Board** (and 1115 Waiver website). Please note that the provider is required to respond to all questions in the template to be eligible for achievement and payment. The Sustainability template should be saved using the following naming convention: RHPXX_TPIXXXXXX_M4_OctDY6 (e.g., RHP01_123456789_M4_OctDY6). The completed Sustainability template should be uploaded to the first project's M-4 milestone in the DSRIP Online Reporting System. Please note that this template is at the provider level and contains all of the provider's projects, so the provider only needs to upload it once.

The template itself acts as a Progress Update, so the provider is not required to enter a Progress Update on the M-4 milestone tab. During the October DY6 reporting period, instead of seeing an open Progress Update field, the provider will see instructions as to where to download and upload the Sustainability Template.

For detailed guidance and a walk through of how to complete the DY6 Sustainability template, please refer to the DY6 Sustainability Template Companion Document, which is posted on the DSRIP Bulletin Board and 1115 Waiver website.

CATEGORY 3

General Information

- All providers **must submit a Category 3 template** in the October DY6 reporting period, whether they are reporting achievement of a Cat 3 milestone or not. Providers in multiple regions will submit one template per RHP.

- Providers **will not** use the online reporting system to report or provide status updates on **Category 3 PM-10, PM-12, AM-2.x, and AM-3.x** milestones or **PFPM** milestones. Reporting status and progress updates will be reported solely in the Category 3 Reporting Template for these milestones. Providers will be able to review reporting results in the online reporting system after the end of the reporting review period.
- Providers **will** use the online reporting system to report and provide status updates on DY5 Stretch Activity milestones, if not yet reported, and to provide status updates and report on **DY6 Stretch Activity** milestones (**PM-11**).
- Performance year measurement periods (PYs) that end by 09/30/2017 can be reported during October DY6 reporting for Category 3 outcomes and PFPM milestones with approved baselines. Certain Category 3 outcomes will be eligible to correct baseline and/or reported performance through the October DY6 measurement period. Eligible outcomes can be corrected, even if performance is not being reported at this time. Correction eligibility will be indicated in the template.
- October DY6 is the last opportunity to report for achievement of DY5 milestone AM-2.x. Providers reporting partial achievement of AM-2.x in PY2 will be able to report for achievement of AM-2.x in PY3A. Since many PY3A measurement periods end 09/30/2017, data pulls may not be complete to report by 10/31/2017. Providers may request an NMI in the Category 3 reporting template, and use the NMI reporting period to report for carried forward achievement of AM-2.x in PY3. Only providers who have or are reporting AM-2.x as partially achieved in PY2 and need additional time to report PY3 will be eligible to request to report in the NMI reporting period.
- Please send Category 3 questions related to October DY6 reporting to the Healthcare Transformation mailbox by **Friday, October 20th**, especially if they involve making corrections to reporting templates.

Supporting Documentation

October DY6 reporting documents are available on the **DSRIP Bulletin Board** in the DSRIP Online Reporting System.

- Category 3 Reporting Template (Required)
 - This template is required of all providers, whether reporting achievement of Cat 3 or not.
 - The template is submitted for reporting of both Category 3 outcomes (PM-10, PM-12, AM-2.x, AM-3.x) and PFPM milestones (AM-3.x). A separate PFPM template will not be used to report in October DY6.
 - The template should be attached only once to the first Category 3 outcome associated with the first Category 1 or 2 project in the online reporting system.
 - Save the Reporting Template as: RHPXX_TPIXXXXXXXX_Cat3_OctDY6.xlsm (e.g., RHP01_123456789_Cat3_OctDY6.xlsm).
- Category 3 Reporting Template Certification:
 - The Chief Quality Officer or executive responsible for validating accuracy of Cat 3 reporting should print the summary tab of the reporting template, sign, and upload a copy of the signed certification with the reporting template.
- Stretch Activity 3 (SA3) Program Evaluation Coversheet (if applicable):
 - This coversheet should be completed for Stretch Activity 3 (Program Evaluation) alternate improvement activities reporting for achievement and uploaded directly to each PM-11 milestone along with the full program evaluation. ***The coversheet alone does not meet requirements of SA3. Providers must also upload a completed project evaluation.***

- Save the coversheet as: RHPXX_Cat3ProjectIDXXXXXXXX.X.X_SA3_OctDY6 (e.g., RHP01_123456789.3.1_SA3_OctDY6.xlsm).
- HHSC does not require a coversheet for Stretch Activities other than SA3.
- Stretch Activity 9 (SA9) Cost Benefit Analysis Template (if applicable):
 - When reporting achievement of an SA9 stretch activity, providers must submit an approved template listed on the [SA9 Guidance](#) (or a template that HHSC has approved if provider has requested an exception).
 - Save the template as: RHPXX_Cat3ProjectIDXXXXXXXX.X.X_SA9_OctDY6 (e.g., RHP01_123456789.3.1_SA9_OctDY6.xlsx).
 - The provider should also upload a narrative report addressing the two questions outlined in the Guidance document.
- Stretch Activity Reports (if applicable):
 - Completed reports for Stretch Activities should be uploaded directly to the PM-11 stretch activity milestone. Date ranges that show when the activity/report was completed should be included within each document.
 - Supporting document(s) must be uploaded for each stretch activity metric reporting for achievement. The same document(s) may be used for multiple PM-11 projects if appropriate.
 - Save the report as: RHPXX_Cat3ProjectIDXXXXXXXX.X.X_SA#_OctDY6 (e.g., RHP01_123456789.3.1_SA#_OctDY6.xlsx).

Providers should maintain internal records of the reports used to abstract the numerator and denominator for Category 3 outcomes and PFPM measures to ensure that the same abstraction method is used across measurement periods, should HHSC or the compliance monitor ask to see additional details.

All reporting is subject to compliance monitoring. In cases where compliance monitoring determines that actual achievement is less than reported achievement, payments above actual achievement will be recouped.

Providers are required to adhere to measure specifications as outlined in the Category 3 Compendium and to maintain a record of any variances that were approved by HHSC prior to reporting baseline. Approval of a reported baseline or performance year does not constitute approval to report outside measure specifications. If at any point HHSC or a Compliance Monitor identifies that a provider is reporting a Category 3 outcome outside measure specification, DY5 and DY6 performance reporting payment may be withheld or recouped and the provider will be required to bring reporting into compliance with Category 3 specifications.

Measurement Periods

All performance measurement periods should be a full twelve months, even if the measure specifications or administration methodology indicate a shorter measurement period. For example, for flu admission rate specifications (IT-2.19), providers would still report the start and end dates of the measurement period of 12 months, even though the rate will only report on data during flu season as specified. Similarly, a provider might only administer quality of life surveys (for example, IT-10.1.a.x) one month out of a year as they are reporting on the same population year over year, but should report

their performance measurement period as a full 12 months for DSRIP reporting purposes. Outcomes reporting performance with less than 12 months of data will result in an NMI determination.

Baselines:

Category 3 Outcomes

Category 3 outcomes are required to submit a baseline with 6 - 12 months of baseline data (with few exceptions), with measurement periods that start as early as 01/01/2012 and end no later than 09/30/2014. Baselines that end by 09/30/2014 (the end of DY3) are considered standard baselines for Category 3 milestone and reporting purposes.

In cases where a provider has no or inadequate data to establish a baseline that ends by 09/30/2014 (the end of DY3), DY4 data may be used to establish a baseline. This results in a change to the Category 3 milestone structure in DY4. Outcomes that have been approved by HHSC to report with a DY4 baseline must report a baseline with 12 months of data. The 12-month period should be as early as possible and end no later than the end of DY4. The October DY5 reporting period was the last opportunity for providers who were approved for a DY4 baseline to report a baseline, so no payment will be awarded for the reporting of baseline at this time.

DY6 PFPM Outcomes

For PFPM milestones newly selected in DY6, the baseline should be a 12-month measurement period aligned with either DY4 (10/01/2014 - 09/30/2015) or DY5 (10/01/2015 - 09/30/2016), with some exceptions.

Performance Years:

The term demonstration year (DY) refers to the October 1 - September 30 divisions within the waiver lifecycle (e.g., DY5 is 10/1/15 – 9/30/16). While metric funds are tied to a specific DY, the measurement periods for achievement don't always align with the DY. Cat 3 measurement periods for achievement are referred to as Performance Years (PY). PYs refer to the 12 month period during which a Cat 3 metric can be achieved.

Carrying forward due to partial achievement does not result in a change to the Category 3 PY1, PY2, PY3, or PY4 measurement periods, which are the 12 months immediately following the end of the preceding measurement period. Carrying forward performance means shifting the unachieved portions of an improvement target to the next 12 month PY measurement period.

PY1 and PY2 Measurement Periods

The term PY1, or performance year one, generally refers to the 12 months after a baseline's measurement period, PY2 generally refers to the 12 months following PY1, etc. However, PYs can vary based on the outcome's baseline measurement period and measure type. Some exceptions include:

- In contrast to standard baselines, for outcomes with **DY4 baselines**, the 12 months following baseline is PY2.

- If a provider received approval to report with a **proxy population for baseline**, the first PY measurement period may be non-consecutive from the baseline measurement period. For example, if a provider used a comparable clinic to determine a baseline rate for an outcome using a CY2013 measurement period because the DSRIP project clinic was not open until October 1, 2014, the provider may begin their first PY measurement period (PY1 for Standard Baselines and PY2 for DY4 Baselines) on October 1, 2014. Outcomes not approved to report with a proxy baseline that report a non-consecutive PY measurement period without written prior approval from HHSC will result in an NMI determination.
- PY2 is the first year following the baseline for **DY5 PFPM** outcomes.

PY3 and PY4 Measurement Periods

In DY6 reporting, there are three possible measurement periods:

- **PY3A** is used to report achievement of any **carried forward DY5** milestones. It is the standard 12 month period following PY2. A provider with a DY5 carried forward P4P (AM-2.x*), Maintenance (PM-12*), or PFPM (AM-3.x*) milestone will report the carried forward DY5 goal in DY6 using the PY3A measurement period.
- **PY3B** is used to report achievement of **DY6** milestones. The PY3B measurement period can be defined in the following ways based upon the outcome type:
 - P4R (PM-10): PY3B is the 12 month period immediately following the PY2 measurement period approved for use in DYs 3-5.
 - P4P (AM-3.x), Maintenance (PM-12), or PFPM continuing from DY5 (AM-3.x: PY3B can be either the 12 months following PY2 so that PY3A and PY3B use the same measurement period and report the same rates OR the 12 months that align with DY6 (October 1, 2016 - September 30, 2017).
 - DY6 achievement can be only be reported in October DY6 reporting, if the PY3B end date is on or before September 30, 2017. If a provider chooses to align PY3B with the DY6 measurement period, reporting of DY6 achievement will be delayed to October of DY6. Providers opting to use the non-consecutive PY3B measurement period for DY6 achievement will still need to use the standard PY3A measurement period that follows their PY2 measurement period for achievement of any carryforward from DY5 milestones.
 - P4P of PFPM Newly Selected for DY6 (AM-3.x): For PFPMs newly selected for DY6 where there was no PFPM milestone in DY6 and the selected measure does not duplicate a PFPM selection from DY5, PY3B is DY6 (October 1, 2016 - September 30, 2017) unless otherwise approved by HHSC.
- For providers with a PFPM newly selected in DY6, PY3B is the first opportunity to report performance. **PY4** is used to report achievement of any **carried forward DY6** milestones. It is the 12 month period following PY3B. A provider with a DY6 carried forward P4P (AM-3.x), Maintenance (PM-12), or PFPM (AM-3.x) milestone will report DY6 achievement using the PY4 measurement period.

Summary of Measurement Periods by Outcome Type and Demonstration Year

Outcome Type	DY5 Carryforward of Achievement		DY6		DY6 Carryforward of Achievement	
	Milestone	PY3A Definition	Milestone	PY3B Definition	Milestone	PY4 Definition
P4R	NA	NA	PM-10	12 mos. following PY2	NA	NA
Maintenance	PM-12*	12 mos. following PY2	PM-12	12 mos. following PY2 or DY6	PM-12	12 mos. following PY3B
P4P	AM-2.x*		AM-3.x		AM-3.x	
PFPM	AM-3.x*		AM-3.x		AM-3.x	

Category 3 Milestone Structures in DY5 and DY6

Category 3 milestone structure for DY6 is determined by the approved milestone structure for DY5. Milestone structures vary based on whether an outcome is Pay for Reporting (P4R), Pay for Performance (P4P) or Maintenance outcome.

Milestone Structure in DY5	Milestone Structure in DY6
DY4 Baseline Maintenance SA	Maintenance
DY4 Baseline P4P	P4P
DY4 Baseline P4R PFP	P4P (of PFPM outcome)
DY4 Baseline P4R SA	P4R and Stretch Activity
DY4 Baseline P4R SA	P4P (of PFPM outcome)
Standard Maintenance PFP	P4P (of PFPM outcome)
Standard Maintenance SA	Maintenance
Standard P4P	P4P
Standard P4R PFP	P4P (of PFPM outcome)
Standard P4R SA	P4R and Stretch Activity
Standard P4R SA	P4P (of PFPM outcome)

The milestone structure assigned to a Category 3 outcome can be confirmed in the Category 3 Summary Workbook, as well as in the October DY6 Category 3 Reporting Template. Details on each milestone structure can be found below.

Standard or DY4 Baseline P4P Outcome

Year	Milestone	Milestone Description	Payment
DY5	AM-2.x*	Achievement of DY5 performance goal	100% of Cat 3 DY5 Allocation
DY6	AM-3.x	Achievement of DY6 performance goal	100% of Cat 3 DY6 Allocation

Standard or DY4 Baseline P4R Outcome with DY5 PFPM

Year	Milestone	Milestone Description	Payment
DY5	PM-10	Successful reporting to approved measure specifications	50% of Cat 3 DY5 Allocation
	AM-3.x*	Achievement of DY5 PFPM goal	50% of Cat 3 DY5 Allocation
DY6	AM-3.x	Achievement of DY6 PFPM goal	100% of Cat 3 DY6 Allocation

Standard or DY4 Baseline P4R Outcome with DY5 Stretch Activity and DY6 Stretch Activity

Year	Milestone	Milestone Description	Payment
DY5	PM-10*	Successful reporting to approved measure specifications	50% of Cat 3 DY5 Allocation
	PM-11*	Successful achievement of Stretch Activity	50% of Cat 3 DY5 Allocation

DY6	PM-10	Successful reporting to approved measure specifications	50% of Cat 3 DY6 Allocation
	PM-11	Successful achievement of Stretch Activity	50% of Cat 3 DY6 Allocation

Standard or DY4 Baseline P4R Outcome with DY5 Stretch Activity and DY6 PFPM

Year	Milestone	Milestone Description	Payment
DY5	PM-10*	Successful reporting to approved measure specifications	50% of Cat 3 DY5 Allocation
	PM-11*	Successful achievement of Stretch Activity	50% of Cat 3 DY5 Allocation
DY6	AM-3.x	Achievement of DY6 PFPM DY6 goal	100% of Cat 3 DY6 Allocation

Standard Maintenance Outcome with DY5 PFPM

Year	Milestone	Milestone Description	Payment
DY5	PM-12*	Maintain baseline high performance level	50% of Cat 3 DY5 Allocation
	AM-3.x*	Achievement of DY5 PFPM goal	50% of Cat 3 DY5 Allocation
DY6	AM-3.x	Achievement of DY6 PFPM goal	100% of Cat 3 DY6 Allocation

Providers will maintain statistically significant maintenance of high performance, defined as two proportion z-test with a significance level of .10 (calculator available here: <http://www.socscistatistics.com/tests/ztest/Default2.aspx>). Providers whose DY4 performance stays above their baseline rate do not need to demonstrate statistically significant maintenance. Providers who do not maintain high performance are eligible to carryforward. For example, a provider who did not fully achieve the DY5 PM-12 milestone would be eligible to carryforward for possible achievement in the Category 3 DY6 measurement period.

Standard or DY4 Baseline Maintenance Outcome with DY5 Stretch Activity

Year	Milestone	Milestone Description	Payment
DY5	PM-12	Maintain baseline High Performance Level (HPL)	50% of Cat 3 DY5 Allocation
	PM-11	Successful achievement of Stretch Activity	50% of Cat 3 DY5 Allocation
DY6	PM-12	Maintain baseline High Performance Level (HPL)	100% of Cat 3 DY6 Allocation

Providers will maintain statistically significant maintenance of high performance, defined as two proportion z-test with a significance level of .10 (calculator available here: <http://www.socscistatistics.com/tests/ztest/Default2.aspx>). Providers whose DY4 performance stays above their baseline rate do not need to demonstrate statistically significant maintenance. Providers who do not maintain high performance are eligible to carryforward. For example, a provider who did not fully achieve the DY5 PM-12 milestone would be eligible to carryforward for possible achievement in the Category 3 DY6 measurement period.

Calculating Performance Goals

DY5 Performance Goals

For those outcomes where the measure type is P4P, DY5 performance goals are determined by the reported baseline using one of three standard goal setting approaches described below, based on the selected improvement target. Performance goals for P4P outcomes with a Quality Improvement System for Managed Care (QISMC) improvement type are calculated based on where a provider's baseline is relative to nationally set benchmarks (Minimum Performance Level (MPL) and High Performance Level (HPL)). The Category 3 Compendium includes details on the HPL and MPL for each QISMC P4P outcome measure.

The table below outlines how performance goals are calculated for P4P measures, excluding IOS and IOS-Survey based outcomes in OD-10 and OD-11.

Improvement Type		Baseline	DY5 Goal
QISMC	Negative Directionality	Below MPL	$MPL - .10(MPL - HPL)$
		Between MPL & HPL	$Baseline - .20 (Baseline - HPL)$
		Above HPL	TA Needed - change to IOS, or maintenance
	Positive Directionality	Below MPL	$MPL + .10(HPL - MPL)$
		Between MPL & HPL	$Baseline + .20(HPL - Baseline)$
		Above HPL	TA Needed - change to IOS, or maintenance

P4P measures where QISMC appropriate benchmarks (HPL and MPL) are not available are designated as Improvement over Self (IOS) measures. In these scenarios, a provider must improve an outcome over the baseline performance. The table below shows the goal settings for IOS P4P goals in DY5. Goals are a 10 percent gap closure towards perfect (the highest possible score - for most outcomes this will be 1 or 0 depending on directionality) over baseline.

Improvement Type		DY5 Goal
IOS	Negative Directionality	$Baseline - .10(Baseline)$
	Positive Directionality	$Baseline + .10(Perfect - Baseline)$

The table below shows the performance goals for survey-based P4P measures in ODs 10 and 11. DY5 performance goals are set based on scenarios selected by the provider at the time of baseline reporting. In Scenario 1, goals are determined by the change in average pretest and posttest scores observed during the baseline measurement period. In Scenarios 2 and 3, goals are determined by a fixed improvement set relative to the minimum possible score and the maximum possible score for a given survey/tool.

Improvement Type			DY5
IOS - Survey	Negative Directionality	Scenario 1 DY3 = Pretest & Posttest DY4&DY5 = Posttest Only	DY5 Posttest Goal: $Baseline Posttest - .10(Baseline Pretest - Baseline Posttest)$
		Scenario 2 DY3 = Pretests Only DY4/DY5 = Posttest Only	DY5 Posttest Goal: $Baseline Pretest - .10*(Baseline Pretest - Min Score)$
		Scenario 3 DY3-5 = Average Score	DY5 Average Score Goal: $Baseline - .10*(Baseline --Min Score)$
	Positive Directionality	Scenario 1 DY3 = Pretest & Posttest DY4&DY5 = Posttest Only	DY5 Posttest Goal= $Baseline Posttest + .10(Baseline Posttest - Baseline Pretest)$
		Scenario 2 DY3 = Pretests Only DY4/DY5 = Posttest Only	DY5 Posttest Goal: $Baseline Pretest + .10*(Max Score --Baseline Pretest)$
		Scenario 3 DY3-5 = Average Score	DY5 Average Score Goal: $Baseline + .10*(Max Score - Baseline)$

DY6 Performance Goals

P4P outcomes approved to use a standard baseline, outcomes approved to use a DY4 baseline, and P4P outcomes will all use the same goal calculations to determine goals for DY6 milestone AM-3.x. The table below shows the goal setting for QISMC P4P outcomes in DY6. For baselines near the high performance level (HPL), a standardized improvement floor is used. For QISMC outcomes with a

baseline above the HPL, goals are the lesser absolute value of improvement of a 12.5% gap closure towards perfect, or baseline + 10% of the difference between the HPL and MPL in DY6. Using this formula may result in lower DY6 goals for outcomes with a baseline above the HPL, and higher goals for outcomes with a baseline below the HPL.

DY6 QISMC Goal Setting for Category 3 P4P Outcomes

Direction	Baseline	DY6 Goal
Negative	Below the MPL	$MPL - .15*(MPL - HPL)$
	Between the MPL & HPL	the lesser of: baseline - $.25*(baseline - HPL)$; or baseline - $.10*(MPL - HPL)$ †
	Above the HPL	the greater of: baseline - $.125*(baseline)$; or baseline - $.10*(MPL - HPL)$ †
	Below the MPL	$MPL - .15*(MPL - HPL)$
Positive	Below the MPL	$MPL + .15*(HPL - MPL)$
	Between the MPL & HPL	the greater of: baseline + $.25*(HPL - baseline)$; or baseline + $.10*(HPL - MPL)$ †
	Above the HPL	the lesser of: baseline + $.125*(1 - baseline)$; or baseline + $.10*(HPL - MPL)$ †

† Goal set using the improvement floor

The table below shows the goal settings for IOS P4P goals in DY6. Goals are a 12.5 percent gap closure towards perfect (the best possible rate, in most cases this will be 1 or 0 depending on directionality) over baseline.

DY6 IOS Goal Setting for Category 3 P4P Outcomes

Direction	DY6 Goal
Negative	baseline - $.125*(baseline)$
Positive	baseline + $.125*(perfect - baseline)$

The table below shows the IOS - Survey P4P goals in DY6 for survey based outcomes in ODs 10 and 11 based on the various reporting scenarios.

DY6 IOS - Survey Goal Setting for Category 3 P4P Outcomes

Direction	Reporting Scenario	DY6 Goal
Negative	Scenario 1	Posttest baseline - $.125*(pretest baseline - posttest baseline)$
	Scenario 2 & 3	Baseline - $.125*(baseline - min score)$
Positive	Scenario 1	Posttest baseline + $.125*(posttest baseline - pretest baseline)$
	Scenario 2 & 3	Baseline + $.125*(max score - baseline)$

PY1 Equivalent Goals

For P4P outcomes where there is no PY1 goal (i.e., outcomes using a DY4 baseline, or PFPM outcomes) or where the PY3 goal is set using a different methodology than used to determine the PY1 goal (i.e., QISMC outcomes with a DY6 goal set using the improvement floor formula, or some IOS-survey goals),

partial payment will be measured as the percent of goal achieved between the PY3 goal and a PY1 equivalent goal, as defined below.

If a category 3 outcome is approved to use a baseline established in DY4 and does not have a DY4 achievement milestone, partial payment will be measured over a PY1 equivalent goal. For PFP outcomes, partial payment will be measured over a PY1 equivalent goal. The PY1 equivalent goal for these outcomes will follow the QISM or IOS goal calculations for PY1.

If a QISM outcome has a PY3 goal that was determined using the improvement floor, partial payment will be measured over the PY1 equivalent goal. If a higher rate (positive directionality) indicates improvement for the outcome, the PY1 equivalent goal is the baseline plus 40 percent of the improvement floor. If a lower rate (negative directionality) indicates improvement for the outcome, the PY1 equivalent goal is the baseline minus 40 percent of the improvement floor.

If an IOS - Survey outcome is using reporting scenario 2 or reporting scenario 3, partial payment will be over the PY1 equivalent goal. If a higher rate (positive directionality) indicates improvement for the outcome, the PY1 equivalent goal is the baseline plus a five percent gap closure towards the maximum score. If a lower rate (negative directionality) indicates improvement for the outcome, the PY1 equivalent goal is the baseline minus a five percent gap closure towards the minimum score.

If a PY1 equivalent goal is used for an outcome, it can be identified in the Goal and Achievement Calculator tab of the Cat 3 Summary Workbook by entering the baseline numerator and denominator into the calculator. In the example below, the provider had a baseline just above the HPL and DY4 and DY5 goals were calculated using the IOS methodology (DY5 goal = Baseline + .10*(1-Baseline)). The DY6 goal is set using the improvement floor (DY6 goal = baseline + .10*(HPL - MPL)) resulting in a slightly lower DY6 goal. Since the DY6 goal is set using the improvement floor, the PY1 goal equivalent for partial payment is also identified.

Example of a PY1 equivalent goal for a DY6 goal set using the improvement floor

Rate Part 1 of 1						
	Numerator	Denominator	Baseline Rate	PY1 AM-1.1 Goal	PY2 AM-2.1 Goal	PY3 AM-3.1 Goal
Baseline	14000	20000	0.7000	0.7150	0.7300	0.7179
				*PY1 equivalent goal for DY6 AM-3.1 partial achievement is 0.7072		*Improvement floor goal
			Performance Rate	AM-1.1 % of Goal Achieved	AM-2.1 % of Goal Achieved	AM-3.1 % of Goal Achieved
Performance Year 1						
Performance Year 2						
Performance Year 3*						
Performance Year 4						

Goal Achievement

Partial Payment and Carryforward

Providers may receive partial payment for making progress toward an eligible P4P outcome improvement target (AM-2.x, AM-3.x). Category 3 P4P outcomes are eligible for partial payment related to percent of goal achieved.

Payment Based on Percent of Goal Achieved

Goal Achievement Reported in DY6	Payment
<i>Less than 25% achievement of DY5 Goal</i>	<i>No Payment for AM-2.x in DY6*</i>
<i>At least 25% achievement of DY5 Goal</i>	<i>25% of funds for AM-2.x in DY6*</i>
<i>At least 50% achievement of DY5 Goal</i>	<i>50% of funds for AM-2.x in DY6*</i>
<i>At least 75 % achievement of DY5 Goal</i>	<i>75% of funds for AM-2.x in DY6*</i>
<i>100% Achievement of DY5 Goal</i>	<i>100% of funds for AM-2.x in DY6*</i>
Less than 25% achievement of DY6 Goal	No Payment for AM-3.x in DY6
At least 25% achievement of DY6 Goal	25% of funds for AM-3.x in DY6
At least 50% achievement of DY6 Goal	50% of funds for AM-3.x in DY6
At least 75 % achievement of DY6 Goal	75% of funds for AM-3.x in DY6
100% Achievement of DY6 Goal	100% of funds for AM-3.x in DY6

**For unachieved portions of DY5 AM-2.x milestones, DY5 and DY6 payments for AM-2.x will not exceed 100% of funds.*

Unearned funds can be carried forward into the next Category 3, 12-month performance measurement period. Achievement may not be carried forward beyond the 12 months following the performance measurement period in which initial achievement was less than the goal.

In DY6, a provider may earn carried forward unearned portions of the DY5 funds AND earn DY6 funds. Unachieved portions of AM-2.x milestones were automatically carried forward and may be earned in the PY3A measurement period. The DY6 AM-3.x milestone may be reported in with PY3B, and unachieved portions of the DY6 milestone may be earned in PY4.

Achievement Calculations

Category 3 goal achievement formulas are determined by the measure directionality (positive or negative) and the baseline measurement period type (Standard or DY4). PFP goals will be calculated the same as other Category 3 outcomes in DY6. Partial achievement for DY6 achievement milestones for PFPs will be measured over a PY1 equivalent goal. Goal achievement can be confirmed in the Category 3 Summary Workbook and Goal Calculator, and is automatically calculated in the October DY6 Category 3 Reporting Template. Goal achievement is calculated as follows:

Achievement Calculations for Category 3 P4P Outcomes

DY	Milestone	PY	Positive Direction (higher rates indicate improvement)	Negative Direction (Lower rates indicate improvement)
DY5	AM-2-x	PY2	$(\text{PY2 achieved} - \text{baseline}) / (\text{DY5 goal} - \text{baseline})$	$(\text{baseline} - \text{PY2 achieved}) / (\text{baseline} - \text{DY5 goal})$
	Carryforward of AM-2.x	PY3A	$(\text{PY3A achieved} - \text{baseline}) / (\text{DY5 goal} - \text{baseline})$	$(\text{baseline} - \text{PY3A achieved}) / (\text{baseline} - \text{DY5 goal})$
DY6	AM-3.x	PY3B	$(\text{PY3B achieved} - \text{PY1 goal or equivalent}) / (\text{DY6 goal} - \text{PY1 goal or equivalent})$	$(\text{PY1 goal or equivalent} - \text{PY3B achieved}) / (\text{PY1 goal or equivalent} - \text{DY6 goal})$
	Carryforward of AM-3.x	PY4	$(\text{PY4 achieved} - \text{PY1 goal or equivalent}) / (\text{DY6 goal} - \text{PY1 goal or equivalent})$	$(\text{PY1 goal or equivalent} - \text{PY4 achieved}) / (\text{PY1 goal or equivalent} - \text{DY6 goal})$

Providers reporting performance will report the numerator and denominator for their 12-month measurement period(s) in the reporting template. The template will calculate the AM-2.x and/or the AM-3.x percentage of goal achieved.

Example of Goal Achievement Calculation with Positive Directionality

Baseline	0.5527
DY4 Goal	0.5666
DY5Goal	0.5804
DY6 Goal	0.5873
PY2 Achievement Reported in DY5	0.5775
PY3A & PY3B Achievement Reported in DY6 (provider used same measurement period for PY3A and PY3B)	0.5895

DY5 AM-2.1 % of goal achieved in PY2 = (PY2 achieved - baseline)/(DY5 goal - baseline)

$$(0.5775 - 0.5527)/(0.5804 - 0.5527) = 0.8953 \text{ or } 89.5\%$$

AM-2.1 = 75% of goal achieved in PY2

DY5 AM-2.1 % of goal achieved in PY3A = (PY3A achieved - baseline)/(DY5 goal - baseline)

$$(0.5895 - 0.5527)/(0.5804 - 0.5527) = 1.33 \text{ or } 133\%$$

AM-2.1 = 100% of goal achieved in PY3A

DY6 AM-3.1 % of goal achieved in PY3B = (PY3B achieved - PY1 goal or equivalent))/(DY6 goal - PY1 goal or equivalent)

$$(0.5895 - 0.5666)/(0.5873 - 0.5666) = 1.11 \text{ or } 111\%$$

AM-3.1 = 100% of goal achieved in PY3B

In this example, the provider was eligible to receive 75% of funds associated with this AM-2.1 milestone based on PY2 reporting in DY5, and carried forward the unearned 25% into the DY6 reporting period. Based on PY3 reporting in DY6, the provider is eligible to receive the additional 25% of unearned funds carried forward from DY5 milestone AM-2.1 and is eligible to receive 100% of funds associated DY6 milestone AM-3.1.

Corrections to Category 3 Outcomes

The October DY6 Category 3 Reporting Template will automatically allow corrections for some outcomes. Correction eligibility will be included in the template. Most P4P outcomes that have not yet reported performance will be able to make corrections to the reported baseline numerator and denominator through the reporting template. Most P4R outcomes will be able to make corrections to all prior reporting history. Outcomes that are eligible to make corrections in the reporting template can submit corrections if they are reporting new performance rates for possible payment or providing a status update only.

P4P outcomes that have already reported performance and some outcomes with custom goal calculation methodology (i.e., HHSC Approved Alternate Achievement Request, Maintenance, P4P change to P4R) will not be able to automatically make corrections in the reporting template.

Providers that identify errors in previously reported baseline/performance in the Category 3 reporting template should contact HHSC before **October 20th** explaining the error. In some cases, HHSC may give instructions for making corrections in the reporting template. Please contact HHSC as soon as possible if you identify errors in previously reported rates. **Providers should NOT report performance against a baseline known to be incorrect.** HHSC cannot accept corrections to baselines referenced only in the qualitative fields of the reporting template.

After the October DY6 reporting period, HHSC will have another Category 3 Interim Correction period for outcomes that have already reported performance or are not eligible to submit corrections through the October DY6 Category 3 Reporting Template.

Combined Projects

Due to the combining of Cat 1 and 2 projects for DY6, the Cat 3 DY5 carryforward milestones and DY6 milestones may appear on different project reporting pages in the online reporting system. **DY5 Carryforward milestones** will be displayed on the original project's DY6 project reporting page. **DY6 milestones** will be displayed on the combined DY6 project reporting page.

Example: Cat 1 projects RHP 2 - 123456789.1.1 (with associated Cat 3 project RHP 2 - 123456789.3.1) and RHP 3 - 123456789.1.1 (with associated Cat 3 project RHP 3 - 123456789.3.1) were combined into project RHP 2 - 123456789.1.1 for DY6. Because the reporting system designates the link between a Cat 1 or 2 project and Cat 3 project over the course of the waiver instead of by the demonstration year AND because the two outcomes share the same project ID, RHP 3 - 123456789.3.1 was given a new DY6 project ID: RHP 2 - 123456789.3.601. The provider would view their DY6 milestones for RHP 2 - 123456789.3.1 and RHP 2 - 123456789.3.601 on the DY6 project reporting page for RHP 2 - 123456789.1.1. The DY5 carryforward milestones for RHP 2 - 123456789.3.1 would appear on the DY6 project reporting page for RHP 2 - 123456789.1.1 and RHP 3 - 123456789.3.1 would appear on the DY6 project reporting page for RHP 3 - 123456789.1.1.

Stretch Activities (PM-11)

DY5 Stretch Activity milestones (PM-11*) are eligible to be reported in October DY6, provided they are completed by 09/30/2017. DY6 Stretch Activity milestones (PM-11) are considered annual reporting milestones and are now eligible to be reported in October DY6.

Stretch Activity 3 (SA3) Program Evaluation

When reporting achievement of an SA3 (Program Evaluation) stretch activity, providers must submit both a standard SA-3 Coversheet and a full program evaluation document. HHSC does not require a coversheet for Stretch Activities other than SA3.

Stretch Activity 9 (SA9) Cost-Benefit Analysis

When reporting achievement of an SA9 (Cost-Benefit Analysis) stretch activity, providers must submit an approved template listed on the [SA9 Guidance](#) (or a template that HHSC has approved if provider has requested an exception), as well as a narrative report addressing the two questions outlined in the Guidance document. A coversheet is not required for SA9.

CATEGORY 4

Providers will report DY6 Category 4 Reporting Domains in October of 2017 if the measurement periods for a Reporting Domain are complete by September 30th, 2017. There is no carry forward for Category 4. Providers who do not meet reporting specifications may be subject to need more information (NMI) requests from HHSC following the April and October reporting periods.

Providers will be reporting on five Reporting Domains (RDs) in DY6, and all RDs should be reported in a single DY6 Category 4 template. **Responses to qualitative questions must be included for all applicable submitted RDs.**

Save file as: *RHPXX_TPIXXXXXXXXX_Cat4_OctDY6 (RHP01_123456789_Cat4_OctDY6)*

- RDs 1, 2, & 3:
 - The Institute for Child Health Policy (IHP), which is Texas' Medicaid External Quality Review Organization (EQRO), prepared reports based on Calendar Year 2015 Medicaid and CHIP data for hospitals for reporting domains RD-1 – Potentially Preventable Admissions, RD-2 – 30-day Readmissions, and RD-3 – Potentially Preventable Complications. HHSC will provide the individual reports on RD-1, RD-2, and RD-3 to hospitals by the end of March or early April. This data will not be re-sent for the October reporting period. If an individual report needs to be re-sent to a provider, please contact HHSC at TXHealthcareTransformation@hhsc.state.tx.us.
 - The DY6 measurement period is calendar year 2015 and RDs 1-3 may all be reported in April or October 2017.
 -
- RDs 4 & 5:
 - Hospitals will also report the RD-4 – Patient Centered Healthcare and RD – 5 Emergency Department measures based on all-payer data submitted by the individual provider.
 - Providers will have the option of reporting RDs 4 and 5 for Medicaid only data, if available. In DY6, providers will report this in a field designated for Medicaid only data.
 - The DY6 measurement period for RDs 4 and 5 are determined by the DY5 measurement period. The DY6 measurement periods will be the 12 months immediately following the end of the measurement period reported in DY5. Providers will be eligible to report RD-4 and RD-5 in October 2017 only if their DY6 measurement period ended no later than September 30, 2017. Reporting domains not eligible to report in April because of their DY6 measurement period will report in October 2017.
 - HHSC will not accept measurement periods of less than 12 months.
 - Providers are not required to submit additional documentation beyond the *Category 4 Reporting Template*. However, providers are subject to additional monitoring at any time and should maintain the documentation for their Category 4 data.

Category 4 Template Instructions

Reporting Domains 1, 2, & 3:

Providers will confirm that they received the relevant reports or that they did not have sufficient eligible admissions/readmissions to receive a given report, and respond to qualitative questions for each reporting domain. **Providers that do not receive a report because of low volume are still required to respond to qualitative questions.**

The EQRO has compiled data reports for Potentially Preventable Admissions/Readmissions/Complications and providers will use this data to populate the qualitative fields within RD-1, RD-2, and RD-3.

- Responses to qualitative questions must be included for all applicable submitted RDs. Example responses below may be brief statements that would need elaboration.
 1. How does the currently documented number of [PPAs, PPRs, or PPCs] represent an increase or a decrease over the last reporting period? What factors have contributed to any increase or decrease? (e.g., We had a 35% decrease in readmissions from last year and we feel this is due to an increase in patient navigator retention. Patients that were previously frequent readmits are now receiving disease management in outpatient clinics as a result of navigator services.)
 2. **How is this information used to inform any changes to your current processes and procedures?** (e.g., We use the data in our quarterly Quality Committee, where leadership from all departments attend as a means of increasing organizational data transparency, demonstrating interdisciplinary collaboration, and supporting discord for evidence-based patient care. As a result, leaders are able to disseminate the information to their staff and exchange feedback on processes and procedures. When necessary, those communications are fielded to the Quality department for collaboration in formal performance improvement.
 3. **How does this Medicaid only rate compare to [PPAs, PPRs, or PPCs] rates for your broader population?** (e.g., The Medicaid-only rate is higher than the Non-Medicaid rate because most of the patients we serve are Medicaid; e.g. We are unable to compare due to system limitations; e.g. We estimate that the Medicaid-only rate is lower than the Non-Medicaid rate because our payer mix shows that we served more Non-Medicaid patients).
 4. **Do you track PPA/PPC/PPR rates for your broader all-payer population? And if so, what trends are observed?** (e.g., Yes, it seems the [PPA/PPC/PPR] rates are higher for our Medicaid population because most of the patients we serve are Medicaid. The data collected by our quality department and lead patient navigator also seems to suggest the same as many readmissions and complications are Medicaid-derived. Like last year, top likely Medicaid-derived, DRGs were associated with conditions such as CHF, PNE, and COPD. We are hopeful that we can improve patient outcomes with our new outpatient clinic that focuses on internal medicine and the recruitment of a second interventional cardiologist).

5. If PPAs/PPCs/PPRs are zero, is it because of a low Medicaid service volume, or processes/procedures in place that are effectively addressing potentially preventable events amongst all patient served in your facility? (e.g., PPAs/PPCs/PPRs are zero/are low because we are a small provider and service a smaller population. When PPAs/PPCs/PPRs are increased during a particular quarter, we review cases with the appropriate performance improvement teams and take action as necessary).
 6. Describe any established processes/policies/procedures in place to identify and address PPAs/PPCs/PPRs in your facility.
- Please note that responding "Yes" to reporting RD-1, RD-2, and/or RD-3 during the reporting period will open up questions about the population service breakdown.

*****Responses of "NA" should include an explanation. *****

Reporting Domain 4:

Component 1: Patient Satisfaction

For RD-4 Component 1, providers will report the percentage of survey respondents who choose the most positive, or "top-box" response for the following measures, displayed below.

For additional information, visit:

http://www.hcahpsonline.org/Files/HCAHPS_Fact_Sheet_June_2015.pdf

Data is publicly reported and available on Hospital Compare:

<https://www.medicare.gov/hospitalcompare/About/Survey-Patients-Experience.html>

- HCAHPS Reporting Measures:
 - Percent of patients who reported that their doctors "Always" communicated well
 - Percent of patients who reported that their nurses "Always" communicated well
 - Percent of patients who reported that their pain was "Always" well controlled
 - Percent of patients who reported that staff "Always" explained about medicines before giving it to them
 - Percent of patients who reported that YES, they were given information about what to do during their recovery at home.
 - Percent of patients who reported that their room and bathroom were "Always" clean
 - Percent of patients who reported that the area around their room was "Always" quiet at night
 - Percent of patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).
 - Percent of patients who reported YES, they would definitely recommend the hospital.

HHSC is unable to grant exceptions to the use of HCAHPS unless there is a reason that using HCAHPS would be inappropriate for the population served.

Component 2: Medication Management

For RD-4 Component 2, providers will report on NQF measure 0646. The measure specifications can be found on the NQF website [here](#), and in the Category 4 section of the RHP planning protocol.

If manual chart review is required, please use the following sampling guidelines:

- For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.
- For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
- For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

Instructions to hospitals reporting alternate Medication Reconciliation for RD-4 Component 2

Several hospitals have communicated that they have a comprehensive medication reconciliation process, but it deviates from the NQF 0646 measure because they do not provide patients a list of “do not take” medications on discharge. As such, providers may report their medication reconciliation for RD-4 as follows:

- Select “No” in response to the question “Are you reporting in compliance with NQF 0646”.
- In the quantitative field, include the numerator, denominator, and resulting rate relevant to your medication reconciliation process.
- In the qualitative field, explain 1) what the quantitative measurement represents; 2) that you have a comprehensive reconciliation process; 3) why you have opted to use this process; and 4) what information you have to show that the process is effective.
- Providers that deviate from NQF 0646 will be subject to compliance monitoring for this measure.

Reporting Domain 5:

RD-5 (Admit decision time to ED departure time for admitted patients) specifications are defined in National Quality Forum Measure 0497. The specifications can be searched for [here](#). Note: “Time” and “Provider Time” in the numerator and denominator are used interchangeably. The numbers entered should be all-payer data. Please also include the ED admit decision time to ED departure time for admitted patients information for DSRIP eligible patients in the qualitative response section if available.

If manual chart review is required, please use the following sampling guidelines.

- For a measurement period where the denominator size is less than or equal to 75, providers must report on all cases. No sampling is allowed.

- For a measurement period where the denominator size is less than or equal to 380 but greater than 75, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of not less than 76 cases.
- For a measurement period where the denominator size is greater than 380, providers must report on all cases (preferred, particularly for providers using an electronic health record) or a random sample of cases that is not less than 20% of all cases; however, providers may cap the total sample size at 300 cases.

PAYMENT AND IGT PROCESSING

Categories 1 and 2 Payment Calculations

The amount of the incentive funding paid to a Performing Provider will be based on the amount of progress made and approved within each specific milestone. Each DY6 milestone is valued at 25 percent of the Category 1 or 2 DY6 valuation. Each DY6 milestone must be fully achieved to include it in the incentive payment calculation. A DY5 milestone may consist of one or more metrics. A Performing Provider must fully achieve a Category 1 or 2 DY5 metric to include it in the incentive payment calculation.

Based on the progress reported and approved, each milestone will be categorized as follows:

If consisting of one DY5 metric or is a DY6 milestone:

- Full achievement (achievement value = 1)
- Less than full achievement (achievement value = 0)

If consisting of more than one metric:

- Full achievement (achievement value = 1)
- At least 75 percent achievement (achievement value = .75)
- At least 50 percent achievement (achievement value = .5)
- At least 25 percent achievement (achievement value = .25)
- Less than 25 percent achievement (achievement value = 0)

The Performing Provider is eligible to receive an amount of incentive funding for that milestone determined by multiplying the total amount of funding related to that milestone by the reported achievement value. If a Performing Provider has previously reported progress on a milestone with multiple metrics and received partial funding, only the additional amount it is eligible for will be disbursed.

Example of Category 1 or 2 disbursement calculation:

A Category 1 Project in DY 5 is valued at \$4 million and has one milestone with two metrics and one milestone with three metrics.

The Performing Provider reports the following progress in April and has been approved by HHSC and CMS:

Milestone 1: 100 percent achievement (Achievement value = 1)

- Metric 1: Fully achieved
- Metric 2: Fully achieved

Milestone 2: 66.7% percent achievement (Achievement value = .5)

- Metric 1: Fully achieved
- Metric 2: Fully achieved
- Metric 3: Not Achieved

Disbursement for April reporting: Milestone 1 (\$2 million *1 = \$2 million) + Milestone 2 (\$2 Million *0.5 = \$1 Million) = \$3 Million

By the end of the Demonstration Year, the Performing Provider successfully completes all of the remaining metrics for the project. The provider is eligible to receive the balance of incentive payments related to the project:

Disbursement for October reporting is \$4 million - \$3 million = \$1 million.

Note that DSRIP funds are Medicaid incentive payments that are earned for achieving approved metrics at agreed upon values. Once those funds are earned, neither HHSC nor CMS is prescribing how they are to be spent, but we certainly encourage providers to spend them to improve healthcare delivery, particularly for the Medicaid and low-income uninsured populations.

Category 3 Payment Calculations

October DY6 Category 3 payments are based on performance reported in the *October DY6 Category 3 Reporting Template, documentation submitted for PM-11 Stretch Activity completion if applicable*, and approval of the submission by HHSC and CMS.

For P4R Category 3 milestones, 100 percent of DY6 funding is for reporting to approved measure specifications (PM-10).

For process milestones, a Performing Provider must fully achieve to qualify for the DSRIP payment related to these milestones.

For achievement milestones for an outcome with multiple components/rates the 50% allocation toward achievement (AM-3) is split evenly between the number of components/rates (e.g. AM-3.1 and AM-3.2) and these achievement milestones can be achieved or partially achieved independently.

Example milestone structure for outcomes with multiple components/rates

P4P outcome selected is IT-4.19 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls. This outcome has 3 components or parts (screening, risk assessment and plan of care) with a DY4

value of \$200K and DY5 value of \$300K. The following is a description of the milestone structure and payment allocation by milestone.

- **DY4 Milestones**
 - PM-10 Successful reporting to specs (for all components) \$100K—carry forward eligible, not eligible for partial payment.
 - AM-1.1: Achievement of DY4 goal for component 1 (screening) - \$33K- partial achievement and carryforward eligible.
 - AM-1.2: Achievement of DY4 goal for component 2 (risk assessment) - \$33K- partial achievement and carryforward eligible.
 - AM-1.3: Achievement of DY4 goal for component 3 (plan of care) - \$33K- partial achievement and carryforward eligible.
- **DY5 Milestones**
 - AM-2.1: Achievement of DY5 goal for component 1 (screening) - \$100K- partial achievement and carryforward eligible.
 - AM-2.2: Achievement of DY5 goal for component 2 (risk assessment) - \$100K- partial achievement and carryforward eligible.
 - AM-2.3: Achievement of DY5 goal for component 3 (plan of care) - \$100K- partial achievement available.

For a detailed explanation of **Partial Achievement**, please refer to p. 21 under *Category 3: Partial Payment and Carryforward*.

For information regarding **PFPM Partial Achievement**, please refer to p. 22 under *Category 3: Achievement Calculations*.

Category 4 Payment Calculations

A hospital Performing Provider will be eligible for a Category 4 DSRIP payment for each Reporting Domain within the *Category 4 Template* completed and approved by HHSC and CMS.

Partial payments do not apply to Category 4.

Approved April 2017 Needs More Information (NMI) milestones and metrics

In August 2017, HHSC completed review of April 2017 reporting submissions in response to HHSC requests for more information. Approved Needs More Information (NMI) milestones and metrics will be included in the January 2018 payment processing of October reports. NMI milestones and metrics that were not approved will no longer have access to the associated DSRIP funds.

IGT Processing

In December 2017, HHSC Rate Analysis will notify IGT Entities and Anchors of the IGT amounts by affiliation and IGT Entity by RHP for January 2018 payment processing of approved October reports. The

IGT amounts for April 2017 short IGT, approved NMI milestones and metrics, DY5 carry forward achievement, DY6 achievement, and DY6 monitoring will be indicated as well as a total IGT amount.

Per Texas Administrative Code §355.8204, HHSC may collect up to \$5 million per demonstration year from DSRIP IGT entities to serve as the non-federal share (50 percent IGT/50 percent federal funds) for DSRIP monitoring contracts. For DY6, HHSC will collect \$5 million in Monitoring IGT. The monitoring amount for each IGT Entity is a portion of the \$5 million based on the January 1, 2017 value of the IGT Entity's funded DY6 Category 1-4 DSRIP projects out of all DY6 Category 1-4 DSRIP projects in the state.

HHSC requested 100 percent of the DY6 IGT monitoring amount with July 2017 payment processing of April reports. If the full DY6 IGT monitoring amount was not submitted by an IGT Entity in July 2017, it will be requested with January 2018 payment processing of October reports.

An IGT Entity may either transfer the total IGT amount due for DSRIP and monitoring or an amount less than the total IGT due. If less than the total IGT amount is transferred, then HHSC will account for the IGT monitoring amount first and the remaining IGT will be proportionately used to fund DY5 and DY6 approved DSRIP payments. If an IGT entity does not fully fund its DSRIP payments in January, the remaining IGT amount due for its affiliated projects' achievement may be transferred with July 2018 payment processing of April DY7 reports.

DSRIP payments are made using the Federal Medical Assistance Percentage (FMAP) for the federal fiscal year (October 1 – September 30) during which the DSRIP payment is issued and is not based on the demonstration year FMAP of the achieved milestone or metric. The FMAP for FFY2018 and used for January 2018 DSRIP payment processing of October reports is 56.88. The FFY2018 FMAP of 56.88 will be used for July 2018 DSRIP payment processing of April DY7 reports.

IGT Entity Changes

The IGT Entity(ies) and proportion of funding for each project/outcome are listed on the HHSC website on the [Tools and Guidelines for Regional Healthcare Partnership Participants](#) page under **Demonstration Year 7 Reporting**. By November 17, 2017, HHSC will post the estimated IGT due for April reporting based on milestones and metrics reported as achieved to inform any needed IGT changes. Final IGT due will be based on HHSC review and approval. If you have changes to the IGT Entity, either in Entity or proportion of payment among IGT Entities, listed in the reporting system, please complete the *IGT Entity Change Form* available at <https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/IGT-Entity-Change-Form-%28DY4-6%29.xlsx>. IGT Entity changes must be received no later than **December 1, 2017, 5:00 p.m.** for October reporting DSRIP payment processing. Any changes received after December 1, 2017, will go into effect for the April DY7 DSRIP reporting and payments will be delayed until that time. Note that IGT Entity changes submitted for October reporting will not impact the IGT monitoring amounts since monitoring amounts due for DY6 are based on each IGT entity's proportional share of DY6 Category 1-4 DSRIP projects as of January 1, 2017.

WARNING NOTICE REGARDING SUBMISSION OF SUPPORTING DOCUMENTATION

All information submitted for DSRIP reporting by Texas Healthcare Transformation and Quality Improvement Program §1115 Waiver participants is subject to the Public Information Act ("Act"), Chapter 552 of the Government Code. Certain information, such as commercial or financial information the disclosure of which would cause significant competitive harm, is excepted from public disclosure according to the Act. If you believe that the documentation submitted through this system is excepted from the Act, please note that belief at the beginning of your submission, including the particular exception you would claim.

Providers are required by the HHSC Medicaid Provider Agreement, as well as state and federal law, to adequately safeguard individually identifiable Client Information. While the DSRIP online reporting system is secure, and access is limited to HHSC program auditors, protected health information (PHI) is not required by HHSC and should not be transmitted. As such, Providers are prohibited from submitting Personally Identifiable Information about clients, HIPAA Protected Health Information or Sensitive Personal Information in connection with submittal of meeting the metric. Providers are required to only submit De-identified information [as evidence of meeting a metric]. If Provider inadvertently uploads individually identifiable client information or following discovery of an Event or Breach, the Provider should report this to HHSC Waiver Staff and the Provider's designated privacy official or legal counsel to determine whether or not this is a privacy breach which requires notice to your patients. HHSC will remove the PHI-containing files as necessary, but requests that providers submit de-identified versions of the original documentation and description of corrective actions for auditing and recordkeeping purposes. Providers will cooperate fully with HHSC in investigating, mitigating to the extent practicable and issuing notifications directed by HHSC, for any event or breach of confidential information to the extent and in the manner determined by HHSC. Provider's obligation begins at the discovery of an event or data breach and continues as long as related activity continues, until all effects of the event are mitigated to HHSC's satisfaction.

Definitions

"Breach" means any unauthorized acquisition, access, use, or disclosure of confidential Client Information in a manner not permitted by [this incentive program] or applicable law. Additionally:

(1) HIPAA Breach of PHI. With respect to Protected Health Information ("PHI") pursuant to HIPAA regulations and guidance, any unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted by the HIPAA Privacy Regulations is presumed to be a Breach unless Provider, as applicable, demonstrates that there is a low probability that the PHI has been compromised. Compromise will be determined by a documented Risk Assessment including at least the following factors:

- i. The nature and extent of the Confidential Information involved, including the types of identifiers and the likelihood of re-identification of PHI;
- ii. The unauthorized person who used or to whom PHI was disclosed;
- iii. Whether the Confidential Information was actually acquired or viewed; and
- iv. The extent to which the risk to PHI has been mitigated.

With respect to PHI, a "breach," pursuant to HIPAA Breach Regulations and regulatory guidance excludes:

- (A) Any unintentional acquisition, access or use of PHI by a workforce member or person acting under the authority of HHSC or Provider if such acquisition, access, or use was made in good faith and

within the scope of authority and does not result in further use or disclosure in a manner not permitted under the HIPAA Privacy Regulations.

(B) Any inadvertent disclosure by a person who is authorized to access PHI at HHSC or Provider to another person authorized to access PHI at the same HHSC or Provider location, or organized health care arrangement as defined by HIPAA in which HHSC participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under the HIPAA Privacy Regulations.

(C) A disclosure of PHI where Provider demonstrates a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information, pursuant to HIPAA Breach Regulations and regulatory guidance.

(2) Texas Breach of SPI. Breach means "Breach of System Security," applicable to electronic Sensitive Personal Information (SPI) as defined by the Texas Breach Law. The currently undefined phrase in the Texas Breach Law, "compromises the security, confidentiality, or integrity of sensitive personal information," will be interpreted in HHSC's sole discretion, including without limitation, directing Provider to document a Risk Assessment of any reasonably likelihood of harm or loss to an individual, taking into consideration relevant fact-specific information about the breach, including without limitation, any legal requirements the unauthorized person is subject to regarding confidential Client Information to protect and further safeguard the data from unauthorized use or disclosure, or the receipt of satisfactory assurance from the person that the person agrees to further protect and safeguard, return and/or destroy the data to the satisfaction of HHSC. Breached SPI that is also PHI will be considered a HIPAA breach, to the extent applicable.

(3) Any unauthorized use or disclosure as defined by any other law and any regulations adopted there under regarding Confidential Information.

"Client Information" means Personally Identifiable Information about or concerning recipients of benefits under one or more public assistance programs administered by HHSC.

"De-Identified Information" means health information, as defined in the HIPAA privacy regulations as not Protected Health Information, regarding which there is no reasonable basis to believe that the information can be used to identify an Individual. HHSC has determined that health information is not individually identifiable and there is no reasonable basis to believe that the information can be used to identify an Individual only if:

(1) The following identifiers of the Individual or of relatives, employers, or household members of the individual, are removed from the information:

(A) Names;

(B) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

(i) The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and

(ii) The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(C) All elements of dates (except year) for dates directly related to an Individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

(D) Telephone numbers;

(E) Fax numbers;

(F) Electronic mail addresses;

(G) Social security numbers;

(H) Medical record numbers (including without limitation, Medicaid Identification Number);
(I) Health plan beneficiary numbers;
(J) Account numbers;
(K) Certificate/license numbers;
(L) Vehicle identifiers and serial numbers, including license plate numbers;
(M) Device identifiers and serial numbers;
(N) Web Universal Resource Locators (URLs);
(O) Internet Protocol (IP) address numbers;
(P) Biometric identifiers, including finger and voice prints;
(Q) Full face photographic images and any comparable images; and
(R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (C) of this section; and

(2) Neither HHSC nor Provider has actual knowledge that the information could be used alone or in combination with other information to identify an Individual who is a subject of the information.”

“Discovery” means the first day on which an Event or Breach becomes known to Provider, or, by exercising reasonable diligence would have been known to Provider and includes Events or Breaches discovered by or reported to Provider, its officers, directors, partners, employees, agents, work force members, subcontractors or third-parties (such as legal authorities and/or Individuals).

“Encryption” of confidential information means, as described in 45 C.F.R. §164.304, the HIPAA Security Regulations, the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without the use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. To avoid a breach of the confidential process or key, these decryption tools will be stored on a device or at a location separate from the data they are used to encrypt or decrypt.

“HIPAA” means the Health Insurance Portability and Accountability Act of 1996, as amended by the HITECH ACT and regulations thereunder including without limitation HIPAA Omnibus Rules, in 45 CFR Parts 160 and 164. Public Law 104-191 (42 U.S.C. §1320d, *et seq.*); Public Law 111-5 (42 U.S.C. §13001 *et. seq.*).

“HIPAA Privacy Regulations” means the HIPAA Privacy Regulations codified at 45 C.F.R. Part 160 and 45 C.F.R. Part 164, Subpart A, Subpart D and Subpart E.

“HIPAA Security Regulations” means the HIPAA Security Regulations codified at 45 C.F.R. Part 160 and 45 C.F.R. Part 164 Subpart A and Subpart C, and Subpart D.

“HITECH Act” means the Health Information Technology for Economic and Clinical Health Act (P.L. 111-5), and regulations adopted under that act.

“Individual” means the subject of confidential information, including without limitation Protected Health Information, and who will include the subject's Legally authorized representative who qualifies under the HIPAA privacy regulation as a Legally authorized representative of the Individual wherein HIPAA defers to Texas law for determination, for example, without limitation as provided in Tex. Occ. Code § 151.002(6); Tex. H. & S. Code §166.164; and Texas Prob. Code § 3. **“Legally authorized representative”** of the Individual, as defined by Texas law, for example, without limitation as provided in Tex. Occ. Code § 151.002(6); Tex. H. & S. Code §166.164; and Texas Prob. Code § 3, includes:

- (1) a parent or legal guardian if the Individual is a minor;
- (2) a legal guardian if the Individual has been adjudicated incompetent to manage the Individual's personal affairs;
- (3) an agent of the Individual authorized under a durable power of attorney for health care;

- (4) an attorney ad litem appointed for the Individual;
- (5) a guardian ad litem appointed for the Individual;
- (6) a personal representative or statutory beneficiary if the Individual is deceased;
- (7) an attorney retained by the Individual or by another person listed herein; or
- (8) If an individual is deceased, their personal representative must be the executor, independent executor, administrator, independent administrator, or temporary administrator of the estate.

“Personally Identifiable Information” or “PII” means information that can be used to uniquely identify, contact, or locate a single Individual or can be used with other sources to uniquely identify a single Individual.

“Protected Health Information” or “PHI” means individually identifiable health information in any form that is created or received by a HIPAA covered entity, and relates to the Individual's healthcare condition, provision of healthcare, or payment for the provision of healthcare, as further described and defined in the HIPAA. PHI includes demographic information unless such information is De-identified, as defined above. PHI includes without limitation, electronic PHI, and unsecure PHI. PHI includes PHI of a deceased individual within 50 years of the date of death.

“Unsecured Protected Health Information” means PHI that is not rendered unusable, unreadable, or indecipherable to unauthorized Persons through the use of a technology or methodology specified by the HITECH Act regulations and HIPAA Security Regulations. Unsecured PHI does not include secure PHI, which is:

- (1) Encrypted electronic Protected Health Information; or
- (2) Destruction of the media on which the Protected Health Information is stored.

APPENDIX A: CATEGORY 1 & 2 CARRYFORWARD GUIDANCE

General Guidance for Non-QPI Metrics

When determining whether a metric was achieved, HHSC reviews the specific metric description language, baseline/ goal language, numeric goal (if applicable) and data source. HHSC also references the project narrative when clarification of the metric intent or target population is needed. Providers should be sure that the documentation they are submitting in support of a metric is in line with this information and that any information not included in these sources or that requires clarification is included in the supporting documents and/ or *Coversheet*.

Annual Metrics: These metrics require a year's worth of data in order to demonstrate achievement and tend to have percentage goals or include a frequency requirement in the goal language (e.g. attend weekly/monthly meetings, produce quarterly reports, etc.). In most cases, these types of metrics are only allowed to report in October.

Deviation from a Metric: If a provider is deviating from a metric, then an explanation is required in the "Progress Update" field (e.g., Project Area 1.3, Metric P-1.1 requires number of patients entered in the registry; provider requests that metric be met with number of patients identified in target population to be entered in the registry, not those actually entered). The provider should also reference the progress update information in their *Coversheet*. HHSC will review the request using both the approved project language and the RHP Planning Protocol and submit the request to CMS for approval if deemed appropriate or request additional information. If approved, payment for the requested deviation may be made in the following reporting period depending on approval date (e.g., if a significant variance is requested in April 2017 and HHSC requests additional information, the variance could possibly be approved in July 2017; payment would be made following the October DY6 reporting period, estimated to be in January 2018.) If the requested deviation is not approved after HHSC has requested additional information, the provider will no longer be eligible for payment for that metric.

DY6 Reported Achievement is less than Previously Reported Achievement: If a provider is reporting on the same metric from DY3 and DY4, but has a lower achievement of their DY5, then an explanation should be provided in the "Progress Update" field. For example, the metric goal describes that the provider will demonstrate an 8% improvement in patients' average reported functional status using a standardized instrument (e.g., PROMIS) in DY3 and a 16% improvement in DY4 relative to the average score reported in DY2 (baseline). In DY3 the provider meets (and exceeds) the metric goal by demonstrating 10% improvement in the average score reported. In DY4 provider reports a 3% improvement in average reported score relative to DY2 baseline, demonstrating less of an improvement in DY4 than was recognized in DY3. In "Progress Update" field, provider explains that the smaller improvement in DY4 was due to implementation of an online assessment that was emailed to patients and this resulted in a much lower response rate; whereas in DY3, a paper assessment was administered to patients in the office immediately post-visit, resulting in a higher response rate and potentially creating a respondent bias.

DY2, DY3, DY4, or DY5 Reported Achievement has Changed: If the reported and approved achievement of a DY2, DY3, DY4, or DY5 metric has changed, please provide an explanation in the

Project Summary section under “Project Overview: Challenges” (e.g., Location of DSRIP project has changed from Clinic A to Clinic B due to flooding and water damage at Clinic A. DSRIP services and QPI goals remain unchanged.).

Baseline has Changed: If the baseline reported in DY2 or DY3 has changed, please provide an explanation in the "Progress Update" field for the metric. The stated DY6 goals must still be achieved. If the DY6 goal includes improvement over baseline, HHSC will review in context of the entire project to determine appropriateness.

Metrics with Multiple Parts: All metric goals must be fully achieved to report “Yes-Completed” under “Achieved by September 30” and be eligible for DSRIP payment (e.g., if a goal has two parts of expanding by 4 hours a week and adding one new exam room, both the expanded hours and new exam room would need to be completed).

General Guidance for Supporting Documentation Used for Multiple Metrics: If the same or similar documentation is used to support multiple metrics, clearly differentiate how each metric was met with similar documentation (e.g., if a metric is using the same curriculum across multiple clinics or for two different chronic care management programs, then demonstrate how different staff were trained on the same curriculum).

Providers Hiring Staff for Multiple Projects: For Categories 1 and 2, providers should not report the same achievement for multiple projects unless it is clear from the approved projects that the overlap makes sense. For example, if a provider reports under two different projects that the provider is hiring one physician and one office manager, the provider should clearly explain if the physician and office manager are the same for both projects and how their time is divided among the projects or if there are two of each. Overlap between projects will be closely reviewed and may not be approved.

Providers Establishing Additional Clinics Providing Multiple Types of Services: For providers establishing additional clinics, expanding existing clinics, or relocating clinics (Project Option 1.1, Milestone P-1), if the clinic will be used for multiple types of services (e.g., OB/GYN and primary care), the provider should clearly explain how the clinic is utilized for the different services. Providers should also be sure to only include data for the type of service that is targeted by their project in their metric calculations.

Early Metric Achievement: DY4 achievement (October 1, 2014 – September 30, 2015) of *non-QPI metrics* may be allowable for DY5 metrics, if HHSC deems appropriate (such as if staff were able to be hired early or a clinic opened a little earlier than expected); however, providers also should be aware that early achievement of metrics is a criterion that will be looked at in compliance monitoring. *QPI metrics* may not count individuals or encounters in an earlier demonstration year. For example, if a project’s QPI goal was 200 in DY5 and 300 in DY6, and the DY5 goal was achieved before the end of DY5, the project could not start counting DY6 achievement until the start of DY6 (October 1, 2016). Early achievement of QPI metrics is not allowed to ensure that projects' impact on patients continues to grow throughout the demonstration period.

Providers Performing Projects in Multiple Regions: If a provider has similar projects in more than one region and the supporting documentation is also the same, then the provider must include an

explanation that the documentation is the same, include the other project's(s') applicable IDs for the documentation, and explain how this documentation meets the metric goals for both projects. HHSC will review on a case-by-case basis. This may be allowable for process metrics when consistent with the approved project. For metrics that report number of patients served, documentation must be provided specific to the patients served in the region.

Supporting Documentation

Please refer to the RHP Planning Protocols for Categories 1 and 2 and your project specific information for guidance regarding types of supporting documentation and data sources for each metric. The planning protocols are available on the 1115 Medicaid Waiver Tools and Guidelines page at <https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/1115-medicaid-waiver-tools-guidelines-regional-healthcare-partnership-participants>.

General Documentation Guidance:

- Providers must include a *Coversheet* for each project for which they are reporting metric achievement, describing how supporting documents demonstrate achievement of each metric on which they are reporting. The *Coversheet* template is posted on the DSRIP Bulletin Board under **October DY6 Reporting**.
 - *Coversheets* include boxes for 5 metrics. If a provider is reporting on more than 5 metrics for a given project in DY6, they will need to submit an additional *Coversheet* for that project.
 - If you are reporting a metric as "No-Partially Achieved" or "No-Not Started", then that metric should NOT be included in the *Coversheet* and supporting documentation should NOT be submitted for the metric. For these metrics, complete the "Progress Update" field as required by semi-annual reporting.
 - If you are only reporting on a QPI metric, that has no additional goals which may require extra documentation or explanations, then you do not need to include a *Coversheet*.
 - Examples of informative coversheets are below:

Metric 1:	
1	Metric ID (e.g., P-1.1): P-5.1
2	Reporting type (select one): Reporting current DY (not carryforward)
3	File name(s) for supporting documentation: 123456789.1.1_J.Doe_Provider_Contract_DY4_20150419.pdf 123456789.1.1_J.Smith Contract_DY4_20150419.pdf 123456789.1.1_Primary_Care_Encounter Summary_DY4_20150419.pdf
4	Page #s demonstrating achievement: For Contracts = Page 1; for Encounters - only one page
5	Describe how the documentation supports achievement of this metric: 123456789.1.1_J.Doe_Provider_Contract_DY4_20150419.pdf - contract on one primary care provider - shows employment as of February 2015. 123456789.1.1_J.Smith Contract_DY4_20150419.pdf - contract on second primary care provider - show employment as of November 2014. This provider is actually at a new location for pediatric patients. 123456789.1.1_Primary_Care_Encounter Summary_DY4_20150419.pdf - one page summary table pulled from patient financial system that shows that both providers are not only employed but currently seeing patients in the first six months of DY4. Our goal for this year is to see 40,144 visits by the end of DY4. Through March 2015, we are at 24,629 and expect to achieve our goal by the end of the measurement year.

Metric 2:	
1	Metric ID (e.g., P-1.1): P-110.1
2	Reporting type (select one): Reporting current DY (not carryforward) ▼
3	File name(s) for supporting documentation: RHP3_123456789.2.1_DY3_Agendas RHP3_123456789.2.1_DY3_SLCReporting
4	Page #s demonstrating achievement: All
5	Describe how the documentation supports achievement of this metric: The agendas are for each of 20 IDD Crisis Learning Collaborative meetings attended by our Staff. This Learning Collaborative was created in April 2013 and consists of approximately 10 organizations with similar projects across the state. The Learning Collaborative conducted conference calls approximately every two weeks in addition to face to face meetings as scheduled among individual members. The Statewide Learning Collaborative Reporting document shows that our IDD Crisis project Director, Jane Doe attended the face to face statewide RHP Learning Collaboratives on DSRIP projects.

- All documentation must demonstrate baseline information as well as the increase or total achievement stated in the goal.** For example, a metric includes a baseline of 2 physicians with a DY4 goal of 2 additional physicians, which they met in DY4, and DY5 goal of 1 additional physician providing services. Documentation of DY5 metric achievement must include identification of the 5 total physicians (the 2 original physicians, the 2 additional physicians hired in DY4 to meet the DY4 goal, and the 1 physician hired to meet the DY5 goal). Hiring documentation must also be included for the 1 physician hired to meet the DY5 goal. The metric may be marked by HHSC as “Needs More Information” if only documentation of 1 new physician is provided. Please see the chart below as an example of what may be submitted to demonstrate baseline. Please refer to the *QPI Reporting Companion Document* for guidance specific to QPI baselines.

Employee Name	Position #	Position Name	FTE	Hire Date	Baseline/Goal Notes
Fran Gomez	1116	Physician	1.00	1/2/2003	Pre-DSRIP
George Powell	1117	Physician	1.00	11/28/2007	Pre-DSRIP
Henry Richards	1118	Physician	1.00	10/28/2014	Hired for DY4 Metric Achievement
Ilene Anderson	1119	Physician	1.00	1/5/2015	Hired for DY4 Metric Achievement
Jennifer Bonds	1120	Physician	1.00	6/15/2016	Hired for DY5 Metric Achievement See attached contract.

- Metrics with a percentage goal type must show how the percentage was calculated and provide documentation of both the numerator and denominator. The goal calculation may be entered in the "Goal Calculation" field in the reporting system or submitted with the supporting documentation.

- If HHSC has provided a response regarding reporting of a milestone/metric, please attach it to the applicable metric when reporting for payment.
- Providers must include dates in supporting documentation to demonstrate achievement occurred by **September 30, 2017** (e.g., date a community assessment was completed, date of hire, date a plan was approved). The date should not just be a date reflecting when the supporting documentation was prepared.
- The related Project ID should be included in the file name of supporting documentation.
- The file name should NOT include special characters (e.g. @, \$, #, %, &, etc.) as they create errors when HHSC reviewers are trying to access the files in the reporting system and slow down the review process.
- Providers should submit documentation in common file formats (e.g., pdf, Microsoft Word, Microsoft Excel, Microsoft PowerPoint, zip files).
- Submitting data in an Excel spreadsheet rather than in a document table (e.g., pdf, Word) is strongly encouraged, as this is more conducive to efficient review of your metric. It is also important for the provider to include a key or description of what is shown in the spreadsheet. If submitting data in another format, providers should include column totals.
- Documentation should be rotated using landscape and/ or portrait settings as appropriate, so that pages are not upside down or sideways.
- Highlight relevant information within the supporting documentation where the support for achieving a particular metric is one section in a larger document. Be sure to include page numbers for the relevant information in the *Coversheet*.
- Links will NOT be accepted as supporting documentation.
- Handwritten notes or photos of handwritten notes will NOT be accepted as supporting documentation (**other than for sign-in sheets from meetings**).
- Providers should review supporting documentation carefully to ensure no Protected Health Information (PHI) is included. Additional information on PHI is included in the Warning Notice at the end of this document. Providers should confirm that confidential information is not visible or accessible before submitting documentation to HHSC. If, for example, the provider redacts (i.e., blacks out) information on a document and scans it, they should confirm that information is not visible on the scanned copy. When submitting data in a spreadsheet, providers should be sure that fields containing confidential information are de-identified or deleted. Providers should not rely on hiding columns in a spreadsheet to protect confidential information.
- Sensitive information such as salaries may be redacted.
- Staff names should NOT be redacted (e.g., hiring forms, training logs).

General Guidance for Common Metrics:

- **Non-QPI Metrics Involving Improvement Over Baseline:** HHSC may refer to baseline periods specified in the custom milestone/metric description or "Baseline/Goal" field. If a baseline period is not specified and is cited as a point of improvement for a subsequent goal, a 12-month baseline period should be provided. A minimum six-month baseline period may be allowed due to delayed project implementation with sufficient provider explanation. If a DY5 metric goal is to demonstrate improvement over DY4 performance, there should no gaps in DY4 and DY5 measurement periods without explanation. For example, if intervention activities began in January 2015 and DY5

achievement is being reported, then the baseline measurement period could be January 2015 - September 2015 (intervention start to end of DY5) and the DY5 achievement measurement period could be October 1, 2015 – March 31, 2016, and be eligible to report in April of DY5.

- **Percent Improvement Metrics:** In those situations where metric achievement is stated as a percentage increase over prior performance and the language could represent a flat increase in the percentage or an increase relative to prior performance (i.e., $X\% + \text{prior performance}$ vs. $X\% * \text{prior performance}$), HHSC may accept either method of measuring percentage improvement if it is not clearly specified in the baseline/goal language or in the narrative. For example, a 15% improvement may be reported as $50\% + 15\% = 65\%$ or $(50\% * 15\%) + 50\% = 57.5\%$. Within the reporting coversheet, provider should clarify how these types of calculations were made and how the calculation aligns with the intention of the goal and where that is supported in the project narrative.
- **Increased Staff Metrics:** For metrics that involve hiring of additional staff to increase care capacity, the goal is that there is an increase in the total number of staff to care for patients due to the DSRIP project and associated funding. HHSC will consider the specific language of the metric and the project when reviewing metrics around increased staff, but the provider should demonstrate as clearly as possible that the staff changes are different than business as usual. For example, business as usual would be "two staff quit on August 31, so we filled those two vacancies within our existing clinic budget." To demonstrate DSRIP achievement, the provider should explain how positions were created or specifically filled to document expansion related to the DSRIP project.
 - Staff must have begun employment by March 31, 2017, and not only signed a contract/agreement to be counted towards increased staff/hiring metrics. (For example, if an employment contract was signed on February 28, 2017, but the physician's start date is April 1, 2017, this metric should wait to report achievement in October 2017.)
 - For Project Area 1.9 projects, mid-level providers may not be counted towards achieving I-22.1 (increase in number of specialist providers) unless they were explicitly stated in the goal as the providers to be hired.
- **Expanded Hours Metrics:** If a goal specifies when the expanded hours are to occur and the expanded hours are changed (e.g., had planned to expand from 5-6 p.m. Monday through Thursday, but instead expanded 5-7 p.m. on Monday and Wednesday), then it will be acceptable as long as the total number of expanded hours remains the same as originally stated and the change makes sense within the context of the project narrative. The documentation must clearly show what the previous hours were (and that they have continued) and that there are additional hours in which appointments are offered.
- **Learning Collaborative Metrics:** For metrics involving learning collaboratives (including regional learning collaboratives), documentation must include the date, agenda, sign in sheet, and a summary of topics discussed and *lessons learned relevant to the project to demonstrate participation*. The provider is not required to make a presentation at the learning collaborative event to demonstrate achievement of the metric. Providers from other regions and non-DSRIP providers may be included in the regional learning collaborative meetings.
 - **Statewide Learning Collaborative:** Providers who plan to use the Summit to meet metrics related to learning collaborative participation should submit documentation of who from the organization attended or viewed the webcast, what sessions they attended/viewed, what they learned from the event and how they plan to apply the information gained to

their DSRIP projects. Please provide information on all sessions attended or viewed via webcast, with a minimum of ½ day or 3 sessions. HHSC will provide a template you may use, but this is not required. If you do not use the template, please be sure all elements as described here are included.

- **Metrics Involving Meetings:** For metrics involving meetings, all meetings must be scheduled and completed as stated in goals to be eligible for April reporting. Dates, agendas and minutes or summaries of meetings must be submitted as supporting documentation.
- **"Number of new ideas, tools, or solutions, for each idea, tool, or solution" Metrics:** The provider must provide documentation of the Plan-Do-Study-Act (PDSA) concepts as well as the ideas, dates, staff involved, and action taken. Another option is to submit a PDSA document for each idea, tool, or solution. A sample template is available on the Institute for Healthcare Improvement (IHI) website at <http://www.ihl.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx>. This site does require registration (at no cost). This site is an excellent resource for providers. A provider may continue to test one or more ideas throughout the year; however, activity must occur weekly.
- **"Implement the "raise the floor" improvement initiatives established at the semi-annual meeting" Metrics:** For metrics requiring implementing "raise the floor" improvement initiatives, the documentation should include a list of ideas that came up during the semi-annual meeting that would apply to the project, a description of the provider's agreement to implement at least one idea and rationale for the selection, a description of the status of implementation, and any details related to the impact of the idea on the project (e.g., improvement on project uptake, outcomes, or spread). Providers with similar projects do not need to select the same "raise the floor" initiative.
- **Training metrics:** For metrics that involve training, the documentation should include the training materials and training logs/sign-in sheets. Training logs/sign-in sheets should clearly identify staff being trained, organizations represented, number of people trained, when the training occurred, and where the training took place. For example, stating that "Andy, Mary, and Julie met with Alex and Nancy on the phone to provide diabetes training on 9/2/16" is unclear as to whether 2, 3, or 5 people were trained. Documentation should also clearly show that the training was completed within an allowable timeframe.
- **Clinical collaborations:** Clinical collaboration agreements being used for supporting documentation should be signed by all parties in order to be accepted for metric achievement.
- Establishing a plan metrics:
 - For metrics that require an implementation plan, the following should be included:
 - Roles and responsibilities of those involved in implementation (providers, partner agencies, working group, etc.).
 - Timeline, including:
 - List of tasks to be completed (e.g., development of policies, procedures, or protocols, staff training, steps to address software needs, etc.).
 - Status of each task (e.g., Not started, In progress, Completed).
 - Scheduled start and completion dates for tasks.
 - Actual start and completion dates for tasks.
 - Name(s) of those responsible for completing tasks.
 - For metrics that require an evaluation plan, the following should be addressed:
 - Type of evaluation implementing (e.g., process and/or outcome evaluation).

- Evaluation questions and measurable outcomes (outputs and outcomes).
- Resources required (funds, partnerships, staff, technology, survey tools, etc.).
- Major activities (including timeline and who is responsible).
- Method for data collection and analysis.
- Plan for communicating and reporting results.
- **Metrics Involving Disseminating Findings:** If a milestone or metric requires “disseminate findings,” if the approved project narrative specified any partnerships or collaborations, the findings should be disseminated to those entities. If the project does not specify any relationships, then the type of information collected would guide to whom the findings should be disseminated. Another option is to disseminate findings with providers with similar projects or reaching similar populations within the RHP.
- **Sample Size:** For milestones or metrics that require a sample size, HHSC suggests use of a sample size calculator like the one available here: <http://www.raosoft.com/samplesize.html>. Assume a confidence level of 95 percent and margin error of 5 percent.

Additional Guidance by Project Option:

Project Option: 1.1

Milestone P-4: Expand the hours of a primary care clinic, including evening and/or weekend hours

Metric P-4.1: Increased number of hours at primary care clinic over baseline.

- Additional Guidance:
 - For expanded hours at existing clinics, provide documentation of previous schedule and new schedule such as brochures or advertisements showing hours before and after expansion, screen shots from a clinic scheduling system clearly showing hours before and after expansion, or other official documents such as letters, memoranda, or meeting minutes describing hours before and after expansion.
 - For new primary care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting dates, new primary care schedule, etc. Sensitive information such as salaries may be redacted. Staff names should NOT be redacted.

Milestone P-5: Train/hire additional primary care providers and staff and/or increase the number of primary care clinics for existing providers

Metric P-5.1.: Documentation of increased number of providers and staff and/or clinic sites.

- Additional Guidance:
 - For new primary care providers and staff (if applicable), provide signed contract(s) or other documentation for new providers and staff with starting dates, position hired for, new primary care schedule, etc. Sensitive information such as salaries may be redacted. Staff names should NOT be redacted.
 - For training, provide documentation of who attended training and when.

- For increased number of primary care clinics, provide documentation such as blueprints or design plans, lease/contract, picture of facility with address, new primary care schedule, etc., as applicable. Also include narrative description in metric reporting or attach separately.

Project Option: 1.2

Milestone P-2: Expand primary care training for primary care providers, including physicians, physician assistants, nurse practitioners, registered nurses, certified midwives, case managers, pharmacists, dentists

Metric P-2.2: Hire additional precepting primary care faculty members. Demonstrate improvement over prior reporting period (baseline for DY2).

- Additional Guidance:
 - For new primary care faculty members, provide signed contract(s)/letter(s) of position acceptance or other documentation with starting dates and positions.

Milestone I-11: Increase primary care training and/or rotations.

Metric I-11.2: Increase the number of primary care trainees rotating at the Performing Provider's facilities

- Additional Guidance:
 - Documentation should include a list of the enrolled primary care trainees, showing the dates that they were enrolled into the program, and documentation of their schedules showing that they started rotations prior to the reporting period deadline (i.e. March 31st for Round 1 and September 30th for Round 2).

Project Option: 1.9

Milestone I-22: Increase the number of specialist providers, for the high impact/most impacted medical specialties

Metric I-22.1: Increase number of specialist providers in targeted specialties

- Additional Guidance:
 - To show an increase in specialist providers, provide documentation such as signed contract(s) or other documentation for new providers and staff with starting dates, new specialty care schedule, etc. Sensitive information such as salaries may be redacted. Staff names should NOT be redacted.
 - Baseline information should be included to show the increase in staff. This could be as simple as a staff roster that includes staff names, position titles, and if they are a part of the baseline or hired as part of the DSRIP project.

Project Option: 2.13

Milestone I-5: Functional Status.

Metric I-5.1: The percentage of individuals receiving specialized interventions who demonstrate improved functional status on standardized instruments (e.g. ANSA, CANS, etc.)

- Additional Guidance:
 - The numerator and denominator used for goal calculation should be included.
 - If this metric is also being used as a QPI metric, then the QPI Template must be submitted along with results of improved functional status.

Project Option: 2.17

Milestone I-40: Assessment and Follow-up

Metric I-40.1: Percentage of target inpatient population members who have been discharged and have received clinician follow-up calls to review treatment plans and assess compliance.

- Additional Guidance:
 - The numerator and denominator used for goal calculation should be included (i.e. the inpatient population members who have been discharged and those who have received clinician follow-up).
 - The provider should include documentation showing which patients received follow up and explain how the provider documented the follow up.

Project Option: Multiple (e.g., Project Option 1.7 - Metric P-10.1, Project Option 2.11 - Metric P-9.1)

Milestone: Review project data and respond to it every week with tests of new ideas, practices, tools, or solutions. This data should be collected with simple, interim measurement systems, and should be based on self-reported data and sampling that is sufficient for the purposes of improvement.

Metric: Description and number of new ideas, practices, tools, or solutions tested by each provider.

- Additional Guidance:
 - This metric is considered an annual metric should only be reported in Round 2 (October) since data collection would occur throughout the demonstration year on a weekly basis.
 - Documentation of the Plan-Do-Study-Act (PDSA) concepts as well as the ideas, dates, staff involved, and action taken should be provided. Another option is to submit a PDSA document for each idea, tool, or solution.
 - Supporting documentation will depend on metric goal language. If the provider mentions a frequency in their goal language, then their documentation should reflect that. For example, if the goal language states that the provider will be completing quarterly summaries on the number of new ideas, practices, tools, or solutions tested, then those quarterly summaries should be included in the submission.